Dream Dental, PC

Patient Information

Date:_____

Name:_____
Last First Middle Initial

I prefer to be called:_____

Sex: ☐ Female ☐ Male ☐ Unspecified

Birth Date:_____ SSN:_____

Home Address:_____
(Street)

_____
(City) (Zip) (State)

Home #_____ Cell #_____

Other #_____

Email:_____

Employer/School:_____

Occupation:_____

Whom may we thank for referring you?

_____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name:_____

Subscriber ID #_____

Group #_____

Subscriber's Name:_____

Relation to Patient:_____

Subscriber's Birth date:_____

Subscriber's SSN:_____

Secondary Dental Insurance

Insurance Co. Name:_____

Subscriber ID #_____

Group #_____

Subscriber's Name:_____

Relation to Patient:_____

Subscriber's Birth date:_____

Subscriber's SSN:_____

Emergency Contact

Name:_____

Relation:_____

Phone #_____

Physician's Name:_____

Date of Last Visit :_____

Phone #_____

Responsible Party

Name:_____

Relation to patient:_____

Address:_____

_____

Phone #_____

Date of Birth:_____

Signature:_____ **Date**:_____

HEALTH HISTORY

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
		Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
		Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
		Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
		Food collection between the teeth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
		Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
		Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
		Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No
		Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss? _____	
		Lip or cheek biting	☐ Yes ☐ No		
		Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush? _____	

Patient's Name: _____

Patient's signature: _____ **Date:** _____

Dream Dental, PC

Treatment consent:

By signing below, I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Dream Dental PC. These procedures include, but are not limited to; Examinations, Radiographs, Dental cleanings, Fluoride treatments, Sealants, Restorations (Composite fillings), Crown and bridge work, Removable prosthesis, Implant restorations, Periodontal treatment including scaling and root planning (Deep Cleaning), Endodontic (root canal) treatments, Extractions, and the use of local anesthetics and/or nitrous oxide. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

I understand that the dentist is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment this existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

This consent shall be considered in effect until rescinded or revoked.

Notice of Privacy Practices:

By signing below, I acknowledge that I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it. Copy of Notice of privacy practices is available on request.

Assignment and Release:

By singing below, I certify that if, I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian: _____ **Relation to Patient:** _____
(if patient is minor)

Signature: _____ **Date:** _____

DREAM DENTAL, PC

OFFICE POLICIES:

Cancellation policy:

- Please provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment.

Broken appointment fee of $45 will be applied:

- If a patient does not show up for their scheduled and confirmed appointment.
- If a patient cancels or reschedules appointment with less than 24 hours' notice.
- If a patient is more than 15 minutes late for their scheduled appointment, the appointment will need to be rescheduled and this will count as a broken appointment.

A patient will be dismissed from the practice:

- If a patient has more than 3 broken appointments in a calendar year.

All patients under the age of 18 must be accompanied by a parent or legal guardian at their appointment.

Our office does not have a setup for childcare or a game room. If your child is disruptive during your appointment time, in consideration of other patients, we will need to reschedule your appointment.

FINANCIAL POLICIES:

Prior to your visit, our office will give you an estimate for your payment/co-payment that will be due at the time of service. Payment will be accepted in Cash, Check, Debit cards, and the following credit cards: Visa, Master, Discover, and American Express. We accept Care Credit as well.

If you are unable to pay the amount due at the time of service, please call the office prior to your appointment to discuss payment options.

We promise to make every effort to verify your benefits and explain them to you in full before services are rendered. However, we cannot guarantee that the benefits taken over phone between our office and your insurance company are always accurate. Please note that all insurance companies have a disclaimer stating that they will not guarantee benefits or payment until a claim has been submitted.

All co-payments made on the day of service is only the best estimate and does not guarantee that you will have zero balance after the insurance pays your claim. At no time will anyone in this office mean to imply that a co-payment is the only part of the total charges you will be responsible for.

If you are uncertain about a certain procedure being covered by your insurance company, we will be more than happy to submit a predetermination of charges at your request, to help you verify coverage.

We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Should your account become delinquent, the usual and customary collection procedures will be utilized. Any collection fees, court costs, legal fees, attorney fees, etc. will be your responsibility.

I accept and acknowledge these policies.

Patient Name: _____

Patient/Parent Signature: _____ Date: _____