



## Patient Information

### PLEASE PRINT

Dr  / Mr  / Mrs  / Ms  / Miss

Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: Male  Female  Transgender

### FOR BILLING PURPOSES ONLY

Street: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Text me  Call me  Email me

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### SCHEDULING PREFERENCES

Appointment Days: M  T  W  Th  F

Appointment Times: Early Mornings  Late Mornings  Early Afternoons  Late Afternoons

### REFERRAL INFORMATION *(Is there anyone that we can thank?)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Online: \_\_\_\_\_

### INSURANCE INFORMATION

Do you have dental insurance: Yes  No

Primary Insurance		Secondary Insurance <i>(if applicable)</i>	
Subscriber Name		Subscriber Name	
Subscriber SSN#		Subscriber SSN#	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Relationship to Subscriber	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

**\*Please present card and driver's license to administrative assistant to be photocopied\***

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

Are you seeing a medical specialist for any conditions? \_\_\_\_\_

DO YOU HAVE OR HAD, ANY OF THE FOLLOWING?	YES
<b>Heart Problems</b>	
▪ Chest pain	<input type="checkbox"/>
▪ Shortness of breath	<input type="checkbox"/>
▪ Abnormal Blood pressure (high <input type="checkbox"/> low <input type="checkbox"/> )	<input type="checkbox"/>
▪ Heart murmur	<input type="checkbox"/>
▪ Heart valve problem (ex. artificial)	<input type="checkbox"/>
▪ Rheumatic fever	<input type="checkbox"/>
▪ Pacemaker	<input type="checkbox"/>
▪ Heart attack/myocardial infarction o If so, how long ago?	<input type="checkbox"/>
<b>Blood Problems</b>	
▪ Easy bruising	<input type="checkbox"/>
▪ Frequent nosebleeds	<input type="checkbox"/>
▪ Abnormal bleeding	<input type="checkbox"/>
▪ Blood disease (anemia)	<input type="checkbox"/>
▪ Ever require a blood transfusion?	<input type="checkbox"/>
<b>Allergy Problems</b>	
▪ Hay fever	<input type="checkbox"/>
▪ Sinus problems	<input type="checkbox"/>
▪ Skin rashes	<input type="checkbox"/>
▪ Asthma (If yes, please bring inhaler)	<input type="checkbox"/>
<b>Intestinal Problems</b>	
▪ Ulcers, acid reflux	<input type="checkbox"/>
▪ Special diet	<input type="checkbox"/>
▪ Constipation/Diarrhea	<input type="checkbox"/>
▪ Kidney or bladder problems	<input type="checkbox"/>
<b>Bone or Joint Problems</b>	
▪ Arthritis, Autoimmune condition	<input type="checkbox"/>
▪ Back or neck pain	<input type="checkbox"/>
▪ Joint Replacement (total hip, pins, implants) o If so, how long ago?	<input type="checkbox"/>
Fainting Spells, Seizures, Epilepsy	<input type="checkbox"/>
Stroke(s)	<input type="checkbox"/>
Frequent or severe headaches	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>
Persistent cough or swollen glands	<input type="checkbox"/>
Premedications required by physician	<input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Tuberculosis, respiratory disease, breathing difficulty	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>
▪ If so, how much?	
Do you smoke, use tobacco, vape, hookah?	<input type="checkbox"/>
▪ If so, how much?	
Hepatitis, jaundice, liver trouble	<input type="checkbox"/>
Herpes, HPV, or other STD	<input type="checkbox"/>
HIV-positive/AIDS	<input type="checkbox"/>
<b>Have you had any hospital, ER, urgent care visits within the past 2 years?</b>	<input type="checkbox"/>

DO YOU HAVE OR HAD, ANY OF THE FOLLOWING?	YES
Glaucoma	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>
History of head injury?	<input type="checkbox"/>
History of addiction, alcohol or drug abuse?	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following?	YES
Local anesthetics (Lidocaine, etc)	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>
Aspirin, acetaminophen, or ibuprofen	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>
Latex or rubber	<input type="checkbox"/>
Other:	

**If you checked 'YES' to any of the above, please provide additional information below.**

**PLEASE LIST ALL CURRENT MEDICATIONS (attach list if needed) Prescription & over-the-counter, supplement dosages**

WOMEN ONLY	YES
Contraceptives or other hormones?	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>
▪ If so, expected delivery date:	
Are you nursing?	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>
• If so, do you have symptoms?	<input type="checkbox"/>

Patient Signature: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date Signatures Obtained: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ How long ago was last visit? \_\_\_\_\_

Did your last dental visit offer any recommendations or alert you to areas of concern? \_\_\_\_\_

What is your immediate dental concern?  
\_\_\_\_\_

How often do you have your teeth professionally cleaned? 3 months  6 months  1 year or more   
 Brush? Rarely  1x/day  2/x day  Floss? Rarely  1x/day  2-3/x week  Before a dental appointment   
 Rate your smile from 1 to 10 (10 being the best): \_\_\_\_ What would improve your personal rating? \_\_\_\_\_

YES	PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES AND PROVIDE ADDITIONAL DETAIL
<input type="checkbox"/>	Do you have sensitive or sore teeth? Please describe:
<input type="checkbox"/>	Do your gums bleed?
<input type="checkbox"/>	Do you have an unpleasant taste or odor in your mouth?
<input type="checkbox"/>	Have you previously had treatment for gum disease (periodontal disease / pyorrhea)?
<input type="checkbox"/>	Have you previously had orthodontic treatment (braces)?
<input type="checkbox"/>	Do you currently wear any type of appliance (retainer, nightguard)?
<input type="checkbox"/>	Do you have jaw muscle or joint p (TMJ problems)?
<input type="checkbox"/>	Do you have jaw clicking or popping?
<input type="checkbox"/>	Does your jaw ever lock open or close?
<input type="checkbox"/>	Do you have difficulty opening your mouth widely?
<input type="checkbox"/>	Do you have tension headaches?
<input type="checkbox"/>	Do you awaken with an awareness of your teeth or jaws?
<input type="checkbox"/>	Are you aware of clenching or grinding your teeth? Daytime: <input type="checkbox"/> Nighttime: <input type="checkbox"/>
<input type="checkbox"/>	Do you have any lumps or swollen areas in your mouth?
<input type="checkbox"/>	Do you have difficulty swallowing or pain with swallowing?
<input type="checkbox"/>	Do you have a dry mouth?
<input type="checkbox"/>	Do you frequently have mouth sores (cold sores, canker sores)?
<input type="checkbox"/>	Have you lost any teeth?
<input type="checkbox"/>	Do you have unfavorable previous dental experiences?
<input type="checkbox"/>	Do you have anxiety about dental visits?
<input type="checkbox"/>	Do you sweat or tremble a lot during examination?
<input type="checkbox"/>	Have you had problems with effectiveness of dental anesthetic?
<input type="checkbox"/>	Are you unhappy with the appearance of your teeth/gums/smile?
<input type="checkbox"/>	Would you like to discuss how to make your teeth whiter?

**If I need dental treatment, I would like:**

<input type="checkbox"/>	a warm blanket
<input type="checkbox"/>	noise-reducing headphones
<input type="checkbox"/>	laughing gas (nitrous oxide)
<input type="checkbox"/>	a sedative to completely relax me

**I Prefer:**

<input type="checkbox"/>	shorter, multiple appointments
<input type="checkbox"/>	longer appointments to get as much done as possible at one time

**SUPPLEMENTAL DENTURE HISTORY (Please fill out if you are wearing a partial or complete denture)**

YES	PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES:
<input type="checkbox"/>	Has your present denture been relined? If so, when?
<input type="checkbox"/>	Is your present denture a problem? Please Describe:
<input type="checkbox"/>	Satisfied with the appearance?
<input type="checkbox"/>	Satisfied with the comfort?
<input type="checkbox"/>	Satisfied with the chewing ability?

When did you receive your first partial or complete denture? \_\_\_\_\_

How long have you worn your present denture? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_



## Media Release Consent

Dental 32 is often asked to show before and after photos and will sometimes use such media for continuing education, scientific journals, and social media. By signing this form, you are consenting to allow Dental 32 and associated team members to use and distribute your photos. **No patient names and identifying information will be used with the photographs.**

**Right to Revoke:** You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action Dental 32 or its staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow Dental 32 to use any photograph or video of me showing the dental work performed by Dental 32 including using the photos in advertising and sharing on the internet.

I waive the right of prior approval and hereby release Dental32 and its staff from any and all claims for damages of any kind based on the use of my photos.

By signing below, I agree and acknowledge that I have read and understand the above Release and agree to all terms as described.

Patient Name: \_\_\_\_\_

Patient's Parent/Guardian Name (if applicable): \_\_\_\_\_

Signature of Patient (or Parent/Guardian of patient): \_\_\_\_\_

Date: \_\_\_\_\_



**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dental 32 has the right to change its Notice of Privacy Practices from time to time and that I may contact Dental 32 at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Patient's Parent/Guardian Name (if applicable): \_\_\_\_\_

Signature of Patient (or Parent/Guardian of patient): \_\_\_\_\_

Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

I attempted to obtain the patient's/patient guardian's signature to acknowledge receipt of the Notice of Privacy Practices but was unable to do so as documented below.

Date	Employee Initials	Reason



**Disclosure and Consent for Use of Health Information**

I, \_\_\_\_\_, do hereby grant permission for Dental 32 to disclose my personal health information to the following personal representative(s):

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Information to be disclosed (please check all that apply):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office

\_\_\_\_\_  
Signature of Patient  
(Parent/ Guardian if Patient is a minor)

\_\_\_\_\_  
Date

**Consent for Use**

In providing the best treatment for our patients, it might be necessary for Dental 32 to email x-rays to other specialists or dentist. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

\_\_\_\_\_  
Signature of Patient  
(Parent/legal Guardian if Patient is a minor)

\_\_\_\_\_  
Date



**Written Financial Policy**

Thank you for choosing Dental 32 for your oral healthcare needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal dental care as affordable and manageable for you as possible. We do this by offering several payment options.

**Payment Options:**

- Cash, Check, Visa, MasterCard, or Discover Card
  - For patients who do not have insurance support, we offer a 5% accounting courtesy to patients who pay with cash or check.
  
- CareCredit Healthcare Credit Card<sup>1</sup> – convenient monthly payment option
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

**Please Note:**

- Dental 32 is a service provider just like any other business, therefore, we require payment in exchange for treatment at the beginning of each and every appointment. Fees paid for the portion of treatment completed are not refundable.
  
- As a courtesy for patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>2</sup>
  
- It is important that we have 24-hour notice in the event you need to reschedule your appointment in order to avoid a broken appointment, late notice, or no show fee (\$50.00).
  
- Consecutive missed and/or rescheduled appointments could result in patient dismissal from our office.
  
- Dental 32 charges \$34.00 for returned checks.
  
- If you have questions, please do not hesitate to ask. We are here to help you receive the dentistry you want and need.

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Printed Patient Name

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Signature of Patient  
(Parent/ Guardian if Patient is a minor)

Date

<sup>1</sup> Subject to credit approval.

<sup>2</sup> If we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.