dental32

Patient Information

PLEASE PRINT

Dr ☐ / Mr ☐ / Mrs ☐ / Ms ☐ / Miss ☐ Today's Date: _____

Name: _____ Date of Birth: _____

Preferred Name: _____ Sex/Gender: _____

Social Security Number: _____

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 ☐ Do you have medical insurance: Yes ☐ No ☐

Primary DENTAL Insurance		**Primary MEDICAL Insurance**	
Subscriber Name		Subscriber Name	
Subscriber SSN#		Identification #	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self ☐ Spouse ☐ Child ☐ Other ☐	Relationship to Subscriber	Self ☐ Spouse ☐ Child ☐ Other ☐
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Please present insurance cards and driver's license to the business team member to be photocopied
If you have secondary dental or medical insurance, please let our D32 Team member know

Medical Health History

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
Heart Problems	
▪ Chest pain	☐
▪ Shortness of breath	☐
▪ Abnormal Blood pressure (high☐ low ☐)	☐
▪ Heart murmur	☐
▪ Heart valve problem (ex. artificial)	☐
▪ Rheumatic fever	☐
▪ Pacemaker	☐
▪ Heart attack/myocardial infarction o If so, how long ago?	☐
Blood Problems	
▪ Easy bruising	☐
▪ Frequent nosebleeds	☐
▪ Abnormal bleeding	☐
▪ Blood disease (anemia)	☐
▪ Ever require a blood transfusion?	☐
Allergy Problems	
▪ Hay fever	☐
▪ Sinus problems	☐
▪ Skin rashes	☐
▪ Asthma (*If yes, please bring inhaler*)	☐
Intestinal Problems	
▪ Ulcers, acid reflux	☐
▪ Special diet	☐
▪ Constipation/Diarrhea	☐
▪ Kidney or bladder problems	☐
Bone or Joint Problems	
▪ Arthritis, Autoimmune condition	☐
▪ Back or neck pain	☐
▪ Joint Replacement (total hip, pins, implants) o If so, how long ago?	☐
Fainting Spells, Seizures, Epilepsy	☐
Stroke(s)	☐
Frequent or severe headaches	☐
Thyroid problems	☐
Persistent cough or swollen glands	☐
Premedications required by physician	☐
Cancer/Tumor	☐
Diabetes	☐
Tuberculosis, respiratory disease, breathing difficulty	☐
Do you drink alcohol?	☐
▪ If so, how much?	
Do you smoke, use tobacco, vape, hookah?	☐
▪ If so, how much?	
Hepatitis, jaundice, liver trouble	☐
Herpes, HPV, or other STD	☐
HIV-positive/AIDS	☐

Have you had any hospital, ER, urgent care visits within the past 2 years?	☐
DO YOU HAVE OR HAD, ANY OF THE FOLLOWING?	**YES**
Glaucoma	☐
Do you wear contact lenses?	☐
History of head injury?	☐
History of addiction, alcohol or drug abuse?	☐

Are you allergic, or have you reacted adversely, to any of the following?	**YES**
Local anesthetics (Lidocaine, etc)	☐
Penicillin or other antibiotics	☐
Sulfa drugs	☐
Barbiturates, sedatives, or sleeping pills	☐
Aspirin, acetaminophen, or ibuprofen	☐
Codeine, Demerol, or other narcotics	☐
Reaction to metals	☐
Latex or rubber	☐
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?	☐
Are you pregnant?	☐
▪ If so, expected delivery date:	
Are you nursing?	☐
Have you reached menopause?	☐
• If so, do you have symptoms?	☐

Patient Signature: _____
Dentist Signature: _____
Date Signatures Obtained: _____

Dental Health History

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

If I need dental treatment, I would like:

☐	a warm blanket
☐	noise-reducing headphones
☐	laughing gas (nitrous oxide)
☐	a sedative to completely relax me

I Prefer:

☐	shorter, multiple appointments
☐	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:
	Has your present denture been relined? If so, when?
	Is your present denture a problem? Please Describe:
	Satisfied with the appearance?
	Satisfied with the comfort?
	Satisfied with the chewing ability?
When did you receive your first partial or complete denture?	
How long have you worn your current 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 Date

(Parent/ Guardian if Patient is a minor)

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 Date

(Parent/legal Guardian if Patient is a minor)

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[1] – 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.[2]

- 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.

_____

Printed Patient Name

_____

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

[1] Subject to credit approval.

[2] 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.