A's Family Dentistry - 4/5/2024

Patient Name

First Name	Last Name

Patient Information (Confidential)

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To help us meet all your healthcare needs, please fill out this form completely online. If you have any questions or need assistance, please ask us and we will be happy to help.

Date	SS #	Birthdate	Home Phone
Cell#	Address	City	State
Zip Code	Email	Driver's License#	Student Status
When confirming appointments how do you prefer to be contacted?		How did you hear about our office? (Check All That Apply)	
Google	Drive By	Brochure	Patient.

Employment Information

Are you currently employed?

Patient's or Parent's Employer	Work Phone	Business Address
City	State	Zip Code
Spouse or Parent's Name	Employer	Work phone

Emergency Contact

Person to Contact in Case of Emergency	Phone

Insurance Information

Insurance Information

Does the patient have insurance?

Name of Insured	Relationship to Patient		Birthdate
SSN #	Name of Employer	Work Phone	Insurance Company
Group #	Policy/ID#	Insurance Company's Address	
City	State	Zip	

Patient Dental History

Last Dental Visit

Have you been to the dentist before?

Name of Previous Dentist	Approximately Date of Last Exam/Cleaning

Dental History

Do you have any of the following?

1. Bleeding gums?	2. Sensitive to hot or cold?	3. Pain?	4. Frequent headaches?
5. Sores or lumps in or near your mouth?	6. Clicking Pain	Difficulty opening/closing	Difficulty in chewing
7. Grinding teeth?	8. Difficult extractions in the\npast?	9. Dentures or partials?	10. Had any prolonged bleeding\nfollowing extractions?

Facial/Jaw Pain

In regard to facial/jaw pain, do you

Have frequent headaches	Avoid certain foods	Experience popping/clicking	Have pain in temples
Have times when your jaw locks open/closed	Have pain in jaw	Currently have a jaw injury	Currently have a head injury
Currently have a neck injury		Currently have pain around ear	

Orthodontic

Have you ever had orthodontic treatment?

Do you have/have you had any of the following?

Night Guard	Oral Surgery	Periodontal Treatment	Your bite adjusted
Any canker sores or cold sores on your lips, tongue, gums, or body	Smile makeover	Cosmetics	Retainer
Teeth straightening		Teeth straightening	

Please explain

Other

Do you have/have you had any of the following?

A history of smoking/dipping	A history of biting cheeks or lip	Tooth-colored fillings	Burning tongue
Wisdom teeth	Tooth replacement	Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth?	Fractured tooth syndrome
Dental phobias		A habit of nail-biting	

Comments

Sleep/Airway Issues

Do you have any sleep/airway issues?

Does the patient tend to be a mouth breather	Does the patient snore at night	Does the patient seem rested in the morning	Is the patient often sleepy during the day
Has the patient seen an ear, nose or throat specialist	Is the patient using a sleep apnea device	Prior TMJ treatment	CPAP

Comments

Authorization and Release

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any of my treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature of Patient (Parent or Minor)	Date

Patient Medical History

Medical Background

Physician	Office Phone	Date of Last Exam

Medication

1. Are you under medical treatment now?	2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	3. Are you taking any medications) including non-prescription medicine?	4. Are you currently taking or have you ever taken osteoporosis medications in the past?

5. Do you use Tobacco?	6. Do you use controlled substances or recreational drugs?

7. Allergies To:

Do you have any allergies?

Local Anesthetics (e.g. novocaine)	Penicillin	Other Antibiotics	Sulfa Drugs
Sedatives	Iodine	Ibuprofen	Tylenol
Codeine	Metals (e.g. nickel, mercury, etc.)	Latex Rubbe	Aspirin

Other

8. Women Only:

Are you a woman?

a) Are you pregnant or think you may be pregnant?	b) Are you Nursing?	c) Are you taking oral contraceptives

Do you have or have you had any of the following?

High Blood Pressure	Hearing Impaired	STD(s)	Heart Attack
Heart Disease	Vertigo	Rheumatic Fever	Mitral Valve Prolapse
Neck Pain	Swollen Ankles	Congestive Heart Failure	Back Pain
Fainting	Cardiac Pacemaker	Chest Pains	Seizures
Heart Murmur	Stroke	Low Blood Pressure	Angina
Hay Fever/Allergy	Epilepsy/Convulsion	Frequently Tired	Glaucoma
Cancer	Anemia	Recent Weight Loss	Radiation Therapy
Emphysema/COPD	Liver Disease	Diabetes	Tuberculosis
Kidney Diseases	Asthma	Stomach Issues/Ulcers	AIDS/ HIV Infection
Arthritis	Thyroid Problem	Sight Impaired	Hepatitis / Jaundice

Joint Replacement or Implant
Other

Certification

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature of Patient (Parent or Minor)	Date

Supplemental COVID-19 Informed Consents

Dental treatment in the Era of COVID-19

Thank you for your continued trust ni our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "coronavirus", at any time or ni any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of al diseases ni our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness ni our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the coronavirus.

Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, and dental staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?	Patient/Parent's Signature	Date

COVID-19 Health Screening Form

If you have been exposed to a communicable disease, you may spread the disease to the dentist, dental staff, or other patients/parents ni the practice.Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with have any of the following symptoms?

Fever (defined as above 99.6 degrees)?	Cough?	Shortness of breath and trouble breathing?	Persistent pain, pressure, or tightness ni the chest?
Have you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease?	I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's dental appointment to a later date.	Patient/Parent's Signature	
Date			

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Date		

Photography Agreement and Release

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We will be taking some photos and videos during your treatment. Most of these pictures and videos are used for planning, records, and lab communication. They are also used to communicate with you about your teeth at different points during your treatment.

We would like to ask for your permission to potentially use your photos and videos for articles, advertisements, office brochures and educational purposes. By signing this agreement, you are giving us your permission to use the photos we take.

I further agree that I will not claim any party whatsoever based on the usage of the images or make any claim that use thereof violates my privacy or any other right I may enjoy.

I represent that I am 18 years of age or older, and that I have read the foregoing and fully understand the contents thereof and fully agree that I am bound hereby.

Thank you!

Printed Name:

Signed:

Date:

HIPAA

Acknowledgement of Privacy Practices Patient Consent Form

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above 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 health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature

Date:	Print Name	I do NOT authorize any information to be discussed with anyone other than myself.	I do NOT authorize any information to be discussed with anyone other than myself.\nI authorize information about my treatment or appointments to be discussed with the following person(s):
1.	Relationship to Patient:		2.

Relationship to Patient:	Do we have your permission to confirm your appointments date and time by:

Voicemail	Email	Text Message

Signature

Date:

Patient Financial Responsibility Agreement

Patient Financial Responsibility Agreement

We are pleased to assist you with any dental insurance coverage you may have. Please be aware that insurance quotes are just an ESTIMATE only. Coverage may be different if your deductible has NOT been met, annual maximum HAS been met, or if your coverage table is lower than average.

As a patient of A's Family Dentistry Office, the following are my responsibilities:

❖\tTo always update the office on any recent changes to my personal information, such as address, phone number and relationship status (married/divorce) if I am NOT the guarantor.
❖\tTo make sure the office always has the current and updated insurance information and provide a copy of my insurance card. Any unpaid services by my insurance due to incorrect insurance information will be my out-of-pocket responsibility.
❖\tIt is my responsibility (or patient's parent or guardian if under the age of 18) to pay in full for all outstanding balances NOT paid by my insurance.
❖\tTo have knowledge and understand my own dental insurance benefits policy.
❖\tAll NON-COVERED services rendered in this office are my out-of-pocket responsibility.
❖\tCOPAY, DEDUCTIBLE AND COINSURANCE are to be PAID IN FULL at the time of the visit.
❖\tAll denied services will be appealed by the office on my behalf. If for any reason my insurance denied the appeal, I will be responsible for the denied services.
❖\tA $35 charge will be applied to my account for any no show/ missed appointments and bounced checks.

OUT OF NETWORK:

Our office accepts most major insurance carriers with PPO plans. If your plan is OUT OF NETWORK, you are required to pay in FULL for all services rendered at the time of the visit. Our office can provide you with the necessary form and a copy of your receipt to submit to your insurance carrier, if needed.

If your plan has OUT OF NETWORK benefits that cover at least 80% of ALL services, our office will accept insurance payments as payment in full. Please see our treatment coordinator for any questions.

I, (PATIENT NAME), acknowledge and fully understand this agreement. As a courtesy, the office will send the bill to my insurance carrier. I am responsible for taking part in the recovery of all my claims. I understand that my insurance is a contract between myself, and my insurance carrier and that A's Family Dentistry has no part in this contract.

Patient Name	Patient/Guarantor Signature	Date: