Getting To Know You As Our Patient

CENTRAL SUFFOLK DENTISTRY

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security No. Driver's License No.	Birthdate
Cell Phone	Email	Sex (Circle One): Male Female
Work Phone	Marital Status (circle one): Single Married Divorced Other	Contact Preferences (circle all that apply) Email Text Phone

Insurance: □ **I have secondary insurance. (Please ask us for the secondary insurance form)**

Primary Insurance Company	Group No.	ID No.

Insurance Subscriber Information (if different from patient):

Name	Home Address	City, State, Zip
Home Phone	Social Security No.	Birthdate
Cell Phone	Driver's License No.	Sex(Circle One): Male Female
Work Phone	Email	Relation to Patient:
Employer	Marital Status (circle one): Single Married Divorced Other	Occupation

Responsible Party (if different from above):

Name:	Birthdate:
Social Security No.	Driver's License No.

How did you hear about our office? _____

Communication and Release

I hear by authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities.
I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

_____ _____

Patient/Parent/Responsible Party (I have read and agree to the content, terms, and conditions listed above) **Date**

MEDICAL HISTORY

CENTRAL SUFFOLK DENTISTRY

PATIENT NAME: First _____ Last _____ Birth Date: MM DD YYYY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No
Please explain:	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No
Please explain:	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No
Please explain:	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No
Please explain:	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No
Are you on a special diet?	☐ Yes ☐ No
Do you use tobacco?	☐ Yes ☐ No
Do you use controlled substances?	☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant?	☐ Yes ☐ No	Taking oral contraceptives?	☐ Yes ☐ No	Nursing?	☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Local Anesthetics	☐ Acrylic	☐ Metal
☐ Latex	☐ Sulfa drugs	☐ Other:			

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

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Have you ever had any serious illness not listed above?		☐ Yes ☐ No					

Comments/ List Medications:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN (at Follow-Up) _____ DATE _____

Informed Consent for Services

CENTRAL SUFFOLK DENTISTRY

Patient Name: _____

Initials _____ **DRUGS, MEDICATIONS, AND SEDATION**

I understand that antibiotics, analgesics, and other medications can cause allergic reaction: redness, swelling, itching, pain, and/or anaphylactic shock. I understand that some medications may cause drowsiness and lack of coordination which can increase with the use of alcohol or other drugs. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain with the potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Initials _____ **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials _____ **PERIODONTAL TREATMENT**

I understand that periodontal disease is a serious, progressive infection, causing gum inflammation and deterioration, bone loss, and can lead to loss of teeth. I understand that after treatment there can be tenderness, swelling, pain, sensitivity to temperature, and/or bleeding. Alternative treatment is available, including gum surgery, replacement teeth, and extractions. I understand that success depends in part on my efforts to brush, floss, and use mouthwash daily, follow maintenance schedule, and other recommendations.

Initials _____ **FILLINGS**

I understand that a more extensive filling that originally diagnosed may be required due to additional decay not seen on an x-ray. I understand that sensitivity to cold or pressure is common after newly placed fillings. I understand that the most common complications are sensitivity to temperature, fracture of the tooth, nerve damage, damage to the teeth, bite changes, and TMJ complications. I understand that all these complications are more likely the longer I wait to seek treatment.

Initials _____ **CROWNS, BRIDGES, AND VENEERS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days of the preparation date. Excessive delays may allow tooth movement or failure in the temporary, which may necessitate remakes. I understand there will be additional charges for remakes due to me delaying permanent cementation.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I hereby authorize _____ and team to proceed with the dental procedures/treatments as have been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for full payment of treatment fees.

Signature of Patient/Responsible Party _____Date _____

Signature of Team member _____ Date _____

Patient Consent for Use and Disclosure of Protected Health Information and Financial Agreement

Patient Consent For Use And Disclosure

I hereby consent to "Dental Care" using and disclosing my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me with a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by forwarding a written request for the same to the Practice.

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice emailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Financial Agreement

I understand that I am financially responsible for my bill for services rendered in this office. Should this bill be sent to my insurance company for my convenience, I understand that I still remain obligated to pay the entire balance, no matter what my insurance company pays. I am responsible for and required to pay to the practice any co-payments as set by my insurance carrier, any unsatisfied deductible or termination of coverage, any amount my carrier deems my responsibility and any amount considered non-covered by my insurance carrier.

I understand that all co-payments are due at the time treatment is rendered and that if my insurance requires any additional co-payments, I will be responsible for payment and will be billed for it.

I hereby authorize payment for my dental treatment to be provided directly to the Practice. If I should receive any insurance payments, I will immediately endorse the payment over to the Practice. I understand that my failure to do so will result in my receipt of a bill for the services rendered. I also understand that I will be responsible for any charges resulting from not providing the most current, correct insurance information to the Practice.

Acknowledgment

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and Patient Consent for Use and Disclosure of Protected Health Information and agreeing to abide by the Practice's financial policies including those enumerated in the Financial Agreement. MY SIGNATURE SHALL SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTORS/TREATMENT FACILITIES IN THE FUTURE

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent and/or rendered services in reliance upon my prior agreement. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____	_____
Signature of Patient or Legal Guardian	With whom can we share your PHI?
_____	_____
Patient's Name	Date
_____	_____
Phone Number (Cell / Home / Work)	Email Address