THE DENTAL SPECIALTY CENTER

ORTHODONTICS • ENDODONTICS • PERIODONTICS • ORAL SURGERY

Welcome to Our Practice

Please complete the following:

Patient Information • Insurance Information & Financial Consent
HIPPA Compliance • Health and Medical History • Advanced Diagnostics and Informed Consent

Patient Information

Name ____________________ Today's Date ____________________

E-mail ____________________ Date of Birth __________ Age ______ Sex ______

Address ____________________ Phone (h) __________ SS# __________

City __________ State __________ Zip ______ Phone (c) __________ Employer __________

Emergency Contact ____________________ Relationship __________ Phone __________

Pharmacy Name ____________________ Pharmacy Phone # ____________________

Referring General Dentist Information

Office Name ____________________ Date of Last Visit ____________________

Dentist Name ____________________ Date of Last Dental X-Ray ____________________

City __________ State __________ Zip ______ Office Phone Number ____________________

Insurance Information & Financial Consent

Dental Insurance

Primary Company ____________________ Policy Holder ____________________

Member ID # ____________________ Relationship __________ Employer __________

Group # ____________________ Date of Birth __________ SS# __________

Medical Insurance

Primary Company ____________________ Policy Holder ____________________

Member ID # ____________________ Relationship __________ Employer __________

Group # ____________________ Date of Birth __________ SS# __________

Financial Consent

An approximated fee is required at the time of service. Verification of insurance benefits is always an estimate and never a guaranteed amount, as remaining dental maximums can be affected daily by multiple claims and providers. After treatment is complete, we will file an insurance claim as a courtesy for you. If for any reason your insurance does not pay what is expected, you will be financially responsible.

____________________ Signature ____________________ Date

HIPPA Consent

By signing below you are giving us consent to confirm appointments, disclose dental information requested by other treating dentists, leave messages/discuss medical or dental history with your pharmacist, request dental information from your insurance company, and/or request dental records when necessary and leave messages regarding your dental insurance. We are required by law to maintain the privacy of protected health information and provide individuals with a copy of our HIPPA compliance notice at the patient's request.

____________________ Signature ____________________ Date

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Medical Health History

Please answer ALL questions honestly and completely. All YES/NO questions must be answered.

HEIGHT ________ **WEIGHT** ________ How many cigarettes a day? ________________

DO YOU SMOKE? ◯ Yes ◯ No How many years? ________________________

Any problems with anesthesia in the past? ◯ Yes ◯ No
Have you ever had a serious illness or hospitalization? ◯ Yes ◯ No
If yes, why? ____

Have you ever had surgery? ◯ Yes ◯ No

If yes, when and what for? *Date of Surgery* ________________ *Reason for Surgery* ____________________

Date of Surgery ________________ *Reason for Surgery* ____________________

When was your last medical check-up and for what purpose?

____

Primary Physician's Name ____________________________________ Phone # ________________________

Address ____

PLEASE LIST ALL OF YOUR MEDICATIONS (INCLUDE CHRONIC PAIN MEDICATION, INSULIN, ASPIRIN, BIRTH CONTROL, BLOOD THINNERS, ETC.)

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? ◯ Yes ◯ No Codeine or other pain killers? ◯ Yes ◯ No

Food products? ◯ Yes ◯ No Aspirin, Motrin, Aleve, or Ibuprofen? ◯ Yes ◯ No

Sedatives, barbiturates? ◯ Yes ◯ No Penicillin or other antibiotics? ◯ Yes ◯ No

Have you or an immediate family member had any problem associated with local anesthesia, and/or intravenous sedation? ◯ Yes ◯ No

If yes, which anesthetic? ________________________________ Relationship? ____________________

Other drug or food allergies not listed above: ____

____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? ◯ Yes ◯ No If yes, for how long? ________________

Have you ever sought professional care or been hospitalized for:

Substance Abuse ◯ Yes ◯ No

Emotional Disorders ◯ Yes ◯ No

Alcoholism ◯ Yes ◯ No

Do you use:

Alcohol ◯ Yes ◯ No How often? ____________

Marijuana ◯ Yes ◯ No How often? ____________

Recreational Drugs ◯ Yes ◯ No How often? ____________

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Medical Health History

Check YES or NO on ALL of the following conditions which you have had in the past or you have right now.

	Yes	No
Blood Transfusion	☐	☐
Heart Attack/Problems	☐	☐
Physical Disability	☐	☐
High Blood Pressure	☐	☐
Pain in Jaw Joints	☐	☐
Recreational Drugs	☐	☐
Mitral Valve Prolapse	☐	☐
Bacterial Endocarditis	☐	☐
Heart Pacemaker	☐	☐
Radiation Therapy	☐	☐
Bleeding/ Bruise easily	☐	☐
Chronis Steroid Meds	☐	☐
Kidney Problems	☐	☐
Pregnant or Trying	☐	☐
Gagging w/ Dental Work	☐	☐
Rheumatism/ Arthritis	☐	☐
CPAP At Home	☐	☐
Liver Disease	☐	☐
Heart Murmur	☐	☐
Fainting	☐	☐

	Yes	No
Fainting	☐	☐
COPD	☐	☐
Sinus Trouble	☐	☐
HIV/AIDS	☐	☐
Thyroid Disease	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
Home Oxygen	☐	☐
Chronic Pain	☐	☐
Organ Transplant	☐	☐
Mouth Pain	☐	☐
Tuberculosis	☐	☐
Anxiety	☐	☐
End Stage Kidney Failure	☐	☐
ADHD	☐	☐
ADD	☐	☐
Schizophrenia	☐	☐
Anxiety	☐	☐
Depression	☐	☐

	Yes	No
Heart Surgery? *When?* ____________	☐	☐
Artificial Joints *When/Which joint?* ____________	☐	☐
Hepatitis *What type?* ______ *Treatment?* ______	☐	☐
Angina/Chest pain *When/How often?* ____________	☐	☐
Cancer *Type/Location* ____________	☐	☐
Shortness of Breath *When?* ____________	☐	☐
Alcohol/Recreation/Drug Abuse *Drug* ____________	☐	☐
Stroke? *When* ________	☐	☐
Diabetes *T1 T2 A1C* ______ Insulin ○ Yes ○ No	☐	☐
Asthma How often do you need to use your inhaler ______	☐	☐
Seizures *Type* ______ *Last seizure* ______	☐	☐
Irregular Heart Beat *What type* ____________	☐	☐
Low Bone Density/Osteoporosis *Medication?* ______	☐	☐
Psychiatric/Mental *Illness Type?* ____________	☐	☐
Chemotherapy *Why/When?* ____________	☐	☐
Headaches/Migraines *How Often?* ____________	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐

Please list ALL medical problems not mentioned above ________________________________

____

____

By signing below, I (patient or guardian) attest that I have given a complete and truthful medical history.

________________________ Signature

________________ Date