Midtown Family Dentistry: Patient Health History

Patient Full Name: _____ DOB: _____ Date: _____

Patient Social Security Number: _____ Patient Sex and Preferred Pronouns: _____

Occupation: _____ Cell Phone Number: _____

Patient Address: _____

Emergency Contact Name_____ Relationship to Patient: _____

Emergency Contact Number: _____ Patient Email: _____

What is the reason for your dental visit today? _____

Were you referred to our office? If so, by whom? _____

Date of your last dental exam and x-rays: _____What was done on your last dental visit? _____

Are you under the care of a medical physician? Y / N Are you in good health? Y / N Date of last physical: _____

Medical Physician's Name: _____ **Medical** Physician's Phone Number: _____

Medical Physician's Address: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Has there been any change in your general health within the past year? If yes, please explain.

_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? Please Explain:

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? _____

Please list all medications, including vitamins, natural, herbal, or dietary supplements:

_____

_____

Do you have any of the following diseases, problems, or conditions:

Active Tuberculosis (TB): Y / N Been exposed to someone with TB: Y / N

Persistent cough greater than a 3-week duration: Y / N Cough that produces blood: Y / N

Have you had a total **JOINT REPLACEMENT** (hip, knee, elbow, finger)? If yes, please list date and type:

_____

Has a physician ever recommended you take a premedication (antibiotic) prior to your dental treatment? _____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE NOTIFY THE FRONT DESK STAFF.

Dental Information:

Please answer the following questions:

Do your gums bleed when you brush or floss? Y / N	Do you have earaches or neck pain? Y / N
Are your teeth sensitive to cold, hot, sweets, or pressure? Y / N	Do you have any clicking, popping, or discomfort in the jaw? Y / N
Is your mouth dry? Y / N	Do you brux or grind your teeth? Y / N
Have you had any periodontal (gum) treatments? Y / N	Do you have sores or ulcers in your mouth? Y / N
Have you ever had orthodontic (braces) treatment? Y / N	Do you wear dentures or partials? Y / N
Have you ever had any problems associated with previous dental treatment? Y / N	Have you ever had a serious injury to your head or mouth? Y / N
Is your home water supply fluoridated? Y / N	Do you participate in active recreational activities? Y / N
Do you drink bottled or filtered water? Y / N	Are you currently experiencing dental pain or discomfort? Y / N

Medical Information

Do you wear contact lenses? Y / N Do you use controlled substances (drugs)? Y / N Do you use tobacco products? Y / N

Do you drink alcoholic beverages? Y / N How many alcoholic beverages do you typically drink in a week? _____

Are you taking or will begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? Y / N

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA,) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes, please provide the type and date you began taking this medication: _____

Women Only

Are you taking birth control pills or hormonal replacement? Y / N Are you nursing? Y / N

Are you pregnant? Y / N If yes, how far along are you? _____

Allergies

Please **circle** if you are allergic to any of the following:

Local Anesthetics	Sulfa Drugs	Metals	Iodine	Penicillin	NSAIDS/Ibuprofen
Aspirin	Codeine	Latex	Antibiotics	Hay Fever/Allergies	

Please list any other allergies:

_____

Please mark if you have any of the following diseases or conditions.

Artificial (prosthetic) heart valve: Y / N Damaged valves in transplanted heart: Y / N

Previous infective endocarditis: Y / N Congenital Heart Disease (CHD): Y / N

Medications: Please mark if you **ARE** taking or **HAVE EVER** taken any of the following medications.

Blood Thinners: Y / N Coumadin: Y / N Warfarin: Y / N

Diet Medications: Y / N Dexfenfluramine: Y / N Fen – Phen: Y / N Pondimin: Y / N

Levoxyl: Y / N Synthroid: Y / N

Medical Diseases and Conditions: Please mark **yes or no** if you have or have had any of the following diseases or conditions.

AIDS	Y / N	GI Problems	Y / N	Nervous Problems	Y / N	Swollen Glands	Y / N
Abnormal Bleeding	Y / N	Glaucoma	Y / N	Organ Transplant	Y / N	Thyroid Problems	Y / N
Anemia	Y / N	Headaches	Y / N	Pacemaker	Y / N	Tonsilitis	Y / N
Arthritis	Y / N	Heart Murmur	Y / N	Psychiatric Care	Y / N	Tuberculosis	Y / N
Artificial Heart Valve	Y / N	Heart Problems	Y / N	Psychiatric Disorder	Y / N	Tumors or Growths	Y / N
Asthma	Y / N	Hemophilia	Y / N	Psychiatric Treatment	Y / N	Ulcers	Y / N
Blood Disease	Y / N	Hepatitis Type: __	Y / N	Radiation Treatment	Y / N	Weight Loss	Y / N
Cancer	Y / N	Hernia Repair	Y / N	Date: _____			
Date and Type: _____		Herpes	Y / N	Respiratory Disease	Y / N		
Chemical Dependency	Y / N	High Blood Pressure	Y / N	Rheumatic Fever	Y / N		
Chemotherapy	Y / N	HIV Positive	Y / N	Scarlett Fever	Y / N		
Date: _____		Infective Endocarditis	Y / N	STD/STI	Y / N		
Circulatory Problems	Y / N	Jaundice	Y / N	Shingles	Y / N		
Congenital Heart Lesions	Y / N	Jaw Pain	Y / N	Shortness of Breath	Y / N		
Cortisone Treatments	Y / N	Joint Replacement	Y / N	Sinus Trouble	Y / N		
Diabetes	Y / N	Kidney Disease	Y / N	Skin Rash	Y / N		
Eating Disorders	Y / N	Liver Disease	Y / N	Substance Abuse	Y / N		
Emphysema	Y / N	Low Blood Pressure	Y / N	Special Diet	Y / N		
Epilepsy	Y / N	Lung Disease	Y / N	Stroke	Y / N		
Fainting/Dizziness	Y / N	Mitral Valve Prolapse	Y / N	Swollen Feet/Ankles	Y / N		

Patient Signature : _____ **Date :** _____

PATIENT CONSENT FORM

TEXT AND EMAILS

If you would like to receive **text messages** regarding your appointments, please list your **cell phone number**:

_____

If you would like to receive **emails** regarding your appointment, please list your **email:**

_____

I understand that this consent form will not expire until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization. By signing your name below, you agree to the above statements.

_____ _____

Date Signature

Midtown Family Dentistry will not, under any conditions, release your private and protected health information without your informed consent. In order to release any form of protected and private health information from our office, we require written and signed consent forms before this information can be released to another party, such as, but not limited to, an insurance company, medical, dental, or specialist office. Therefore, if you wish to have your protected health information disclosed to another party, you must contact our office and provide the required consent forms before this information can be disclosed. By signing this Patient Consent Form, you have acknowledged that if you wish to request disclosure of your private and protected health information that you may do so, but must submit the required documentation prior to this disclosure. I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

_____ _____

Date Signature

PATIENT ACKNOWLEDGEMENTS

CANCELLATION POLICY

It is the practice of our office to see all patients on an appointment basis. We respect your time and make every effort to remain on schedule. We ask that you extend the same courtesy to us. If you are unable to keep your appointment, we request that you notify us at least 2 business days prior to your appointment. When you do so, we are able to offer your time slot to another patient. Patients who fail to provide us with adequate notification time will be charged a missed appointment fee of $81.00. Our office reserves the right to dismiss any patient with more than two cancellations and/or failure to keep an appointment.

If you have any questions or require clarification, please contact our office.

I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

I have read and understand the Cancellation Policy as outlined herein. I agree to the terms described and assume full liability for any fees charged should I fail to abide by these short-notice requirements.

_____ _____

Date Signature

INSURANCE INFORMATION RELEASE

I authorize my insurance company to provide coverage information or pre-determination information required by my dental office or dental care provider, as outlined here, in order to provide me and/or all my dependents on this plan with necessary dental treatment as required by me. I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

_____ _____

Date Signature

ELECTRONIC CLAIM AUTHORIZATION

I understand that my claims may be submitted electronically, and I authorize the release, to my dental benefit carrier, of information contained in claims submitted electronically. I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

_____ _____

Date Signature

Patient Notices and Acknowledgements

We make every effort to keep down the cost of your care. **We do require payment upon completion of your treatment**. Our office does accept Visa/MC, American Express, Discover, CareCredit, and our new in-house program, KLEER.

An estimate of the charge for any procedures or surgery you may require will be given to you upon request. If you have dental insurance, we will file that for you, and they will reimburse you via a check in the mail. If your treatment requires medical insurance, we will do our best to accommodate you in filing this. However, you must have all the medical forms completely filled out.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. We DO NOT accept assignment of benefits. If your company sends payment here, we will refund you within 7-10 days providing there is not a balance on your account.

You are responsible for all collection costs, attorney fees and court costs in the event that your account is placed with collections.

I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

I have read and understand these guidelines for fees and payment.

_____ _____

Date Signature

Our office is considered out of network for all insurances. As denoted previously, payment for all services rendered in our office is due at the time of service. However, we are happy to file your dental insurance for you and reimbursement from your insurance will be sent directly to you via mail.

If you are a new patient, we require information about your previous radiographs to ensure that you receive the proper care. Additionally, dental insurance will not cover a full mouth series, bitewings, or panorex if they have been taken at another dental office within the last year. Therefore, please inform us if you have current radiographs and complete a records release form for us to obtain these radiographs from your previous dental office. You may also contact your previous dental office and request this information and have it sent to our office via mail, email, or in person.

Please note that if you choose to proceed with radiographs in our office and do not notify us prior to your appointment that you have current radiographs from another office your insurance will not reimburse you for the cost of these radiographs.

If you have any questions or concerns about radiographs and whether they are current, please contact our office via email or by phone.

I understand that this consent form **will not expire** until which time that I choose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization.

By signing this form, you acknowledge that you have read the above statements and understand that you assume full liability for any fees charged for radiographs and/or other treatment completed in our office.

_____ _____

Date Signature

HIPAA Authorization Form

Patient's Name: _____ DOB: _____ Date: _____

I, _____, hereby authorize Midtown Family Dentistry to release all medical information, records, test results, and account information pertaining to me, to the following individual(s):

Name: _____ Number: _____ Relationship to the patient: _____

Name: _____ Number: _____ Relationship to the patient: _____

Name: _____ Number: _____Relationship to the Patient_____

I authorize Midtown Family Dentistry to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that this consent form **will not expire** until which time that I chose to revoke/cancel this authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

Signature of the Patient: _____ Date: _____

Relationship to patient if signing on behalf of patient: _____

Print name if signing on behalf of patient: _____

ADDITIONAL CONSENT FOR SPECIFIC CONDITIONS

Please note that the section below **MUST** be completed **regardless** of whether you have the conditions listed below. Additionally, if consent to release this information is given, this information will **only** be released to those listed on the HIPAA form.

Sensitive Information:

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Please check one of the following:

_____ **I consent** to have the above information released to the individual(s) listed on the HIPAA Authorization Form.

_____ **I do not consent** to have the above information released to the individual(s) listed on the HIPAA Authorization Form.

Signature of Patient: _____ Date: _____

Print Name: _____

Relationship to patient if signing on their behalf: _____

HIV/AIDS:

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment separate consent must be given to have this information released.

Please check one of the following:

_____ **I consent** to have the above information released to the individual(s) listed on the HIPAA Authorization Form.

_____ **I do not consent** to have the above information released to the individual(s) listed on the HIPAA Authorization Form.

This consent form **will not expire** until which time the patient revokes/cancels this information authorization by notifying Midtown Family Dentistry in writing of my intent to revoke authorization or change any information to be disclosed to listed individual(s).

Signature of Patient: _____ Date: _____

Print Name: _____

Relationship to patient if signing on their behalf: _____