Clay Center Family Dental Care

PATIENT INFORMATION

First Name: _____M.I._____ Last Name:_____ Preferred Name:_____

Sex: ☐F ☐M Date of Birth:_____ Soc. Sec.#_____ Driver's Lic.#_____

Email: _____ Hm # (_____)_____-_____ Cell (_____)_____-_____

Address_____ City:_____ State:_____ Zip:_____

In case of emergency who should be notified? _____ Phone:_____

Spouse Name or Responsible Party for a Minor: _____

Patient: □ Married □ Divorced □ Widowed □ Single □ Child

Whom may we thank for referring you to our practice?

☐ Radio ☐ Phonebook ☐ Location ☐ Patient _____ ☐ Employee of this office _____ ☐ Other_____

Insurance Information

Employee Name_____
Employee Date of Birth _____
Name of Insurance Co. _____
Address _____
Telephone _____
Program or policy # _____
Group # _____

Medical History

Do you require antibiotic premedication prior to dental treatments? Yes No
*If yes, please explain*_____

Are you currently taking Asprin or Anticoagulants?
(i.e. Warfarin, Eliquis, Xarelto, Brilinta) Yes No

Do you have a history of Bisphosphonate use?
(i.e. Fosamax, Prolia, Reclast, Zometa) Yes No

Do you have a history of radiation, specifically to the head or neck? Yes No
If yes, please explain _____

Do you have Diabetes? Yes No
If yes, please explain what type _____

Have you had any illness, operation, or been hospitalized in the past five years?
*If yes, explain*_____

Smile Evaluation

Do you have specific dental problems? Y□ N□
If yes, explain _____
Do you have dental exams on routine basis? Y□ N□
Do you brush and floss daily? Y□ N□
Do your gums ever bleed? Y□ N□

Do you like the appearance of your teeth? Y□ N□
Are your teeth all in alignment? (straight) Y□ N□
Do you have spaces you don't like? Y□ N□
Do you like the color of your teeth? Y□ N□
Are there old fillings or dental work you don't like looking at? Y□ N□
Have you had an adverse reaction to dental anesthetic in the past? Y□ N□

Do you every have clicking/popping/discomfort in the jaw joint? Y□ N□
Do you clinch or grind your teeth? Y□ N□
Have your past dental experiences been positive? Y□ N□
Do you smoke or chew? Y□ N□

Name of previous dentist: _____
When was the last time you had a full mouth series of x-rays taken? _____

Do you wish to talk to the dentist privately about anything?

_____
_____
_____

Medical information

Reason for today's office visit:

Name/Phone Number of your Physician:

Please List all medications:

Are you allergic to any medications or substances?

☐ Latex ☐Penicillin ☐Codeine ☐Sulfa ☐Aspirin ☐Acrylic ☐Metal ☐Other_____

Women

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

Health History

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Epilepsy/ Seizure	Yes	No
Asthma	Yes	No	Rheumatic Fever	Yes	No
Sickle Cell Disease	Yes	No	Tobacco use	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Alzheimer's Disease	Yes	No
Autism	Yes	No			

Consent for Services & Financial Information – Please Read Carefully

Self- Pay Patients: Payments can be made by cash, check, credit, debit card or third-party financing (ask for information). Payment is due in full at time of service.

BCBS & Delta Insurance Patients: As a courtesy, this office will prepare and submit your insurance forms. All dental services are ultimately your responsibility and by signing this form you agree to pay all co-pays and deductibles ON THE DAY OF SERVICE. You may pay with cash, check, or credit card. If there is any balance not paid by your benefit company within 30days of submission you are responsible for balance. **It is your responsibility to know the parameters of your policy.**

A service charge of 1 ½ % per month (18% per annum) on unpaid balance will be changed to my account if my balance due is not paid within 30 days of billing. One billing statement will be sent at no charge and subsequent statements will incur a fee of $5.00. Any fee estimates or insurance pre-determinations are valid for 60days from the issue date.

Appointments and Appointment Changes

A great deal of work and planning is done for your appointment. Therefore, changes and cancellations to our schedule without adequate notice are catastrophic. For this reason, we ask that any changes to your appointment be made at least 48 hours prior to your scheduled appointment. Please telephone our office for appointment changes. If we are not notified 48 hours prior to your appointment, we regrettably may charge your account. There may be times we will have to change your appointment and we promise to give you adequate notice.

Notice of Privacy Practices as required by HIPAA

We may use our health information for two primary purposes: Treatment and Payment

Treatment: We may disclose your health information to another dentist or physician providing treatment to you.
Payment: We may disclose your health information to obtain payment for services we provide to you (e.g. insurance company)
Other: It is unlikely, but we may be asked to disclose your health information as required by law for disaster relief: to report abuse or neglect; for public health statistics; by court order; to law enforcement agencies; to coroners; medical examiners; organ procurement organizations; to avert serious threat to health or safety; to federal officials for national security and as authorized by state workers compensation laws.

Patient Rights

Access: You have the right to look at or get copies of your health information with certain reasonable restrictions
Disclosure Accounting: You have the right to know when we have disclosed your health information for any purpose other than treatment and/or payment.

I have read the above conditions of treatment, payment and appointments, and agree to their content and I hereby give my consent for treatment for me or for the above-named patient.

X_____

Signature of patient, parent or guardian or responsible party *Date* *Relationship to Patient*