Welcome to Our Practice

Patient Information

Title First Name M.I. Last Name Suffix Date:

I prefer to be called Email:

Address City State Zip

Home Phone Cell Phone Business Phone Ext.

Preferred Contact # Occupation: **Gender** ☐ Male ☐ Female

Preferred Method of Appointment Confirmation: ☐ Phone Call ☐ Text Message ☐ Email

Date of Birth / / Referred By: General Dentist:

Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix

Relationship to Patient

Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:

Title First Name M.I. Last Name Suffix

Address City State Zip

Home Phone Business Phone Ext.

Date of Birth / / Occupation:

Employer

Dental Insurance

Insurance Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #) **Insured ID# or SSN**

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Secondary Dental Insurance

Insurance Company Name:

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #) **Insured ID# or SSN**

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Dental Information

When was your last dental visit? What was done?

When were x-rays taken last? **When was your last dental cleaning?**

Reason for today's visit: **Are you in pain?** ☐ Yes ☐ No For how long?

Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you feel about your smile?

Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:

Have you ever had trouble getting numb or had reactions to local anesthetic?	☐ Yes	☐ No
Please describe:		
Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height: Weight:

Date of last physical exam **Are you now under the care of a physician?** ☐ Yes ☐ No

Current Physician

What condition is being treated?

Physician Name **Phone Number**

Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No

What was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Has anyone suggested you need antibiotics prior to receiving dental care? ☐ Yes ☐ No

Reason:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes ☐ No	Details:	
Aspirin	☐ Yes ☐ No	Details:	
Penicillin or other antibiotics	☐ Yes ☐ No	Details:	
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Details:	
Sulfa drugs	☐ Yes ☐ No	Details:	
Codeine or other narcotics	☐ Yes ☐ No	Details:	
Metals	☐ Yes ☐ No	Details:	
Latex (rubber)	☐ Yes ☐ No	Details:	
Iodine	☐ Yes ☐ No	Details:	
Hay fever/seasonal	☐ Yes ☐ No	Details:	
Food	☐ Yes ☐ No	Details:	
Other			

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes	☐ No	**Drug Addiction**	☐ Yes	☐ No	**Low Blood Pressure**	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	**Emphysema**	☐ Yes	☐ No	**Lung Disease**	☐ Yes	☐ No
Anaphylaxia	☐ Yes	☐ No	**Epilepsy or Seizures**	☐ Yes	☐ No	**Mitral Valve Prolapse**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	**Excessive Thirst**	☐ Yes	☐ No	**Pain in Jaw Joints**	☐ Yes	☐ No
Angina	☐ Yes	☐ No	**Fainting Spells/Dizziness**	☐ Yes	☐ No	**Migraines / Headaches**	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	**Glaucoma**	☐ Yes	☐ No	**Psychiatric Care**	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	**Heart Attack/Failure**	☐ Yes	☐ No	**Radiation treatment**	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	**Heart Murmur**	☐ Yes	☐ No	**Rheumatic Fever**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	**Heart Pace Maker**	☐ Yes	☐ No	**Scarlet Fever**	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	**Heart Trouble/Disease**	☐ Yes	☐ No	**Sickle Cell Disease**	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	**Hemophilia**	☐ Yes	☐ No	**Sinus Trouble**	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	**Hepatitis A, B or C**	☐ Yes	☐ No	**Stomach/Intestinal Disease**	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	**High Blood Pressure**	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	**Irregular Heartbeat**	☐ Yes	☐ No	**Thyroid Disease**	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	**Kidney Problems**	☐ Yes	☐ No	**Tuberculosis**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Leukemia**	☐ Yes	☐ No	**Tumors/Growths**	☐ Yes	☐ No

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

OUR POLICIES

TREATMENT POLICY:
We are committed to providing you with the best possible care and we will treat you with respect. We will recommend treatment that is based on the most current standards. Your treatment options will be reviewed with you and we will answer any and all of your questions regarding these options. Our goal is to give you the information you need to make an informed decision on what care is best for you.

APPOINTMENT POLICY:
We see all patients on an appointment basis. Your appointment time is reserved to meet your dental needs and to provide you with the best possible care. If you are unable to keep your appointment, we ask that you give us notification 24-hours in advance. Failure to give that notification or to miss an appointment may result in a $75 cancellation fee.

FINANCIAL POLICY:
If you have dental insurance, we will gladly pre-authorize your proposed treatment. We will also bill your insurance company for you. Understand that pre-authorizations obtained from your insurance company are estimates only. It is possible that modifications of the treatment plan and/or estimated fees may occur during the course of treatment. Because your insurance policy is a contract between you (the patient) and your insurance carrier, it is your responsibility to contact your insurance carrier with any questions or disputes regarding the policy, covered treatments, and the amount that is covered. Ultimately, you (the patient) are responsible for the timely payment of your account. We ask that payment for the portion of your treatment not covered by your insurance is paid when services are rendered unless previous arrangements have been made with the financial coordinators of the practice. We accept cash, check, Visa, Mastercard or debit card. For any returns "non-sufficient fund" checks, we will assess the bank fee for the return. This fee will not exceed $25.00.

Delinquent accounts will be assessed a 12 % finance charge for all balances 90 days past due, with a minimum of $1.50. If account is assigned to a collection agency, you will be assessed a $50 collection fee. If it becomes necessary to assign your account to collections for any amount owed on this or subsequent visits, you agree to pay all costs and expenses, including reasonable attorney fees.

I understand that I am responsible for all charges incurred, including those not covered by my dental insurance (if applicable) I agree to pay for the services rendered. I assign any insurance payments to be paid directly to Matt J. Hoidal, D.D.S., M.S., P.C. and authorize the release of any information, including diagnosis and treatment records, to my insurance company. If my insurance company denies payment, I agree to be personally responsible for payment.

Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* (Revised 2013) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree than you are bound to abide by such restrictions.

Signature: _____