

# 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 <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
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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 \$50 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: \_\_\_\_\_