THE Dental OFFICE
JACKSON MN

Welcome!

Patient's Full Name: _____ Preferred Name: _____
First Middle Last

Employer Name: _____ Phone: _____

Gender: ○ M ○ F ○ Other Date of Birth: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Responsible Party's Name (if different than above): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

How did you hear about our clinic? ○ Drive By ○ Internet Search ○ Social Media ○ Family/Friend: _____

○ Other: _____

Primary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Secondary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Dental History

Date of Last Dental Visit: _____ Date of Last Cleaning: _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you currently experiencing any dental pain or problems now? ○ Yes ○ No

If yes, please describe: _____

Do your gums bleed when you brush or floss?	○ Yes	○ No	Do you have earaches or neck pain?	○ Yes	○ No
Are your teeth sensitive to cold, hot, sweets or pressure?	○ Yes	○ No	Do you have any clicking, popping, or discomfort in the jaw?	○ Yes	○ No
Does food or floss catch between your teeth?	○ Yes	○ No	Do you brux or grind your teeth?	○ Yes	○ No
Is your mouth dry?	○ Yes	○ No	Do you have sores or ulcers in your mouth?	○ Yes	○ No
Have you had any periodontal (gum) treatments?	○ Yes	○ No	Do you wear dentures or partials?	○ Yes	○ No
Have you ever had orthodontic (braces) treatments?	○ Yes	○ No	Do you participate in active recreational activities?	○ Yes	○ No
Is your home water fluoridated?	○ Yes	○ No	Have you ever had a serious injury to your head or mouth?	○ Yes	○ No

○ Yes ○ No Have you ever been told to take a pre-medication prior to dental treatment?

○ Yes ○ No Have you ever whitened your teeth before? If yes, how: _____

○ Yes ○ No Are you interested in learning about whitening options available?

How do you feel about your smile? _____

_____

Medical History

O Yes O No Are you under a physicians care now? If yes, please explain:

_____

_____

O Yes O No Have you ever been hospitalized or had a major operation? If yes, please explain and list date of procedures:_____

_____

O Yes O No Have you ever had a serious head or neck injury? If yes, please explain:_____

_____

O Yes O No Are you taking any medications, pills or drugs? Are you taking any vitamins (natural or herbal) and/or diet supplements?

If yes, please list:_____

_____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa drugs O Antibiotics O Seasonal Allergies

O Other:_____

O Yes O No Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, Actonel, or other similar drugs?

O Yes O No Are you on a special diet?

O Yes O No Do you use tobacco products?

O Yes O No Do you drink alcoholic beverages?

O Yes O No Do you use controlled substances?

Women: Are you pregnant O Yes O No If yes, # of weeks?_____ Taking oral contraceptives O Yes O No Nursing O Yes O No

Do you have, or have you had, any of the following?

Heart (Surgery, Disease, Attack)	O Yes	O No	Kidney Trouble	O Yes	O No	Hepatitis (A, B, C)_____	O Yes	O No
Chest Pain	O Yes	O No	Ulcers	O Yes	O No	Venereal Disease	O Yes	O No
Congenital Heart Disease	O Yes	O No	Diabetes	O Yes	O No	AIDS/HIV Positive	O Yes	O No
Heart Murmur	O Yes	O No	Thyroid Problems	O Yes	O No	Cold Sores/Fever Blisters	O Yes	O No
High/Low Blood Pressure	O Yes	O No	Glaucoma	O Yes	O No	Blood Transfusion	O Yes	O No
Mitral Valve Prolapse	O Yes	O No	Contact Lenses	O Yes	O No	Hemophilia	O Yes	O No
Artificial Heart Valve	O Yes	O No	Emphysema	O Yes	O No	Sickle Cell Disease	O Yes	O No
Pacemaker	O Yes	O No	Chronic Cough	O Yes	O No	Bruise Easily	O Yes	O No
Rheumatic Fever	O Yes	O No	Tuberculosis	O Yes	O No	Liver Disease/Yellow Jaundice	O Yes	O No
Arthritis/Rheumatism	O Yes	O No	Asthma	O Yes	O No	Neurological Disorders	O Yes	O No
Cortisone Medicine	O Yes	O No	Hay Fever/Allergies/Hives	O Yes	O No	Epilepsy or Seizures	O Yes	O No
Swollen Ankles	O Yes	O No	Latex Sensitivity	O Yes	O No	Fainting or Dizzy Spells	O Yes	O No
Stroke	O Yes	O No	Sinus Trouble	O Yes	O No	Nervous/Anxious	O Yes	O No
Diet (Special/Restricted)	O Yes	O No	Radiation Therapy	O Yes	O No	Psychiatric/Psychological Care	O Yes	O No
Artificial Joints (Hip, Knee, etc.)	O Yes	O No	Chemotherapy	O Yes	O No	Other:_____	O Yes	O No
Year_____			Tumors	O Yes	O No			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform The Dental Office of any changes in medical status.

Anesthetics are frequently used in dental procedures. This anesthesia may be local, inhalation, or intramuscular. Though rare, risks are associated with injections of anesthetics and may include swelling, bruising, infection, nerve damage, or unexpected reactions involving other complications, even death. My signature below indicates I am aware of these risks.

Patient/Responsible Party Signature:_____ Date:_____

Dentist Signature:_____

THE Dental OFFICE
JACKSON MN

Notice of Privacy Practices Acknowledgement Form

Patient's Name (First Name, Last Name): Date of Birth:

I understand that as part of my care The Dental Office creates and maintains health records that describe my health history, symptoms, examinations, test results, diagnoses, procedures, treatments, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at The Dental Office (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes, including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations, such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from The Dental Office defines more information regarding the use and disclosure of my protected health information as well as my rights to my health information. By signing this, I acknowledge that The Dental Office has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosure for treatment, payment, and healthcare operations purposes for The Dental Office.

I authorize The Dental Office to communicate regarding my billing, appointments to the following individual(s):

_____

_____

I understand that The Dental Office communicates through text messaging about appointment reminders that contain patient-specific information. I agree to the communication through text messaging unless I select the box below.

☐ I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: The Dental Office, 604 2nd Street, Jackson, MN 56143; if the consent is canceled, it will not change releases that have already been made prior to the date of cancellation. I don't want the consent to never expire; please expire the consent as of:_____.

_____ _____

Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect.)_____

Optional: Please e-mail me a copy of the Notice of Privacy Practices to the following e-mail address:

_____

Internal Use:

If patient refuses to sign, please have two staff members of The Dental Office sign below:

_____ _____

Staff's Signature Staff's Signature

Reason for Refusal of Signature:_____

THE Dental OFFICE
JACKSON MN

Dental Insurance

Please be prepared to show your current dental insurance card at each visit.

Your insurance is a contract between you, your employer (if applicable) and the insurance company. At our practice, we will file your insurance claim for you. As a courtesy, we will assist you with information; however, if you have any additional questions about coverage, please contact your insurance company or human resources department. **Patient is responsible for understanding the terms and limits of his/her benefits.** Treatment recommended by our dental professionals is never based on what your insurance company will pay, but on what our team feels is the best for your overall dental health.

Our goal is to maximize your insurance benefits. Please remember that insurance is not designed to cover 100% of the cost of all types of dental treatment. At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover (also called "copay").

Insurance Signature on File. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I furthur agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

Authorized Signature of Covered Person/Employee:_____

Financial Considerations

At our practice, we strive to provide patients with comfortable financing options for affording their dental treatment. Payment arrangements are required before beginning any treatment that is not covered 100% by dental insurance.

- Dental Services provided by our office are an agreement between the patient and the doctor.
- Patients who do not have insurance are required to pay at the time of service.
- Patient portion is due at the time of your appointment. For services that require multiple visits, payment is due at the first visit.
- The parent who requests treatment for the child is responsible for all fees for services rendered.
- I understand that a finance charge will be assessed for accounts over 60 days.
- Delinquency – in the event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 35% of the balance due), along with reasonable attorney fees and court costs incurred by this office.
- THIRD PARTY FINANCING:
  CareCredit offers deferred interest for larger treatment plans. A minimum purchase is required, and subject to credit approval. For more information visit **www.carecredit.com**

Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic and deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatments mutually agreed upon by me and to employ such assistance as required to provide proper care.

Initials:_____

Consent for Contact

The Dental Office staff members may contact me by phone, text, or e-mail with reminders to schedule an appointment for any treatment not completed or to schedule a hygiene visit.

Initials:_____

Records Release

In the event that I request my records to be transferred to another dental provider, I authorize the release of my records in advance.

Initials:_____

Patient/Responsible Party Signature:_____ **Date:**_____