thrive Dental

In order to serve you properly, we will require the following information. All information is strictly confidential. **(Please Fill out Completely)**

Patient's Name: _____
Last First MI

Social Security: _____ Sex: (M) (F) Date of Birth:_____
MM/DD/YYYY

Reason for todays visit?_____

Please indicate who you would like to see: ____Dentist ____Orthodontist ____Both

How did you hear about our office(**Circle all that apply**)?

Google, Yelp, Instagram, Facebook, Youtube, Pinterest, Friend, Family, Insurance carrier

Did anyone specifically refer you? (**Yes/No**) Name of referral:_____

Responsible Party Information:

Name: _____ Marital Status: _____
Last First MI

Address: _____ APT#_____

City: _____ State:_____ Zip Code: _____

Ph: _____ Email: _____ Work: _____

Date of Birth: _____ Relationship to Patient: _____
MM/DD/YYYY

Insurance Information:

Name of the primary account holder: _____

Relationship to the subscriber? ____ Self ____Spouse ____Child

Name of the insurance company: _____ Employer Name: _____

Subscriber/Member I.D.:_____ D.O.B. of Account Holder:_____

Insurance phone number: _____ Group number: _____

Policy holders name for **secondary insurance** (if applicable): _____

Relationship to the subscriber? ____ Self ____Spouse ____Child

Name of the insurance company: _____ Employer Name: _____

Subscriber/Member I.D.:_____ D.O.B. of Account Holder:_____

Insurance phone number: _____ Group number: _____

Emergency Contact Name:_____ **Ph::**_____

MEDICAL HISTORY

List all medications/vitamins/supplements that you are now taking:

_____

_____

_____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa Drugs
		Other:_____			

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever
		Other: _____			

Tobacco use? If so, what kind and how much? _____

Are you currently seeing a physician? (Yes/No)

Name and address of physician: _____

Dental History

What would you like to change about your smile? (ex: Do you want more white, straight, healthy teeth or veneers?) _____

When was the patient's last visit to the dentist?:_____ Month(s) _____ Year(s)

Has the patient ever seen an Orthodontist? (Yes/No) If yes, when was the last visit? _____

Is the patient interested in a **Free Orthodontic Consult**? (Yes/No)

When was the patient's last cleaning? _____ Month(s) _____ Year(s)

Is the patient having any sensitivity towards hot/cold food or drinks? (Yes/No)

Is the patient in pain? (Yes/No)

FINANCIAL AGREEMENT

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE
It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our front desk for an approximate cost prior to treatment. For convenience, we accept cash, American Express, VISA, MasterCard, Discover, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE
Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE OR IN OFFICE DENTAL PLAN
It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment, please ask our front desk for an approximate cost prior to treatment. For convenience, we accept cash, American Express, VISA, MasterCard, Discover, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

If you have dental insurance, we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless of what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services on the assumption your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. We charge a $35 billing charge for any statement sent 90 days after charges were incurred.

In order to hold your appointment time, we require confirmation. If you have not confirmed 24 hours before your appointment, you will be moved off the schedule to allow another patient to take that time. If you confirm an appointment but do not show, we charge a $35 fee for each missed appointment. If you come to your appointment without confirming, we will try our best to accommodate you, but we cannot guarantee treatment.

I have read and understand the above financial and office policy agreement.

Patient Name:_____ Date:_____

Signature:_____ Relationship to Patient:_____

WEBSITE CONSENT FORM TO POST PICTURES

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient Name:_____ Date:_____

Signature:_____

☐ Check below if you **do not allow** Thrive Dental and Orthodontics to use any of my or my children(s) pictures for marketing purposes.

DENTAL RADIOGRAPHS

Dental X-rays: An Overview

Everyone's oral health is different, and a visual examination is not enough to tell the dentist everything they need to know during your visit. X-rays, or radiographs, are just as important as regular cleanings and allow the dentist to see between the teeth, inside the teeth, the roots of the teeth, and the bone around the teeth in order to check for any hidden problems not visible to the naked eye. This allows us to detect any issues that may not be causing you pain.

The US Federal Drug Administration (FDA) and American Dental Association (ADA) have set guidelines and regulations for what x-rays to take and how frequently they can be taken. New patients require more x-rays to ensure their mouths are healthy, but as you continue your regular checkups, fewer x-rays are needed at your next visits.

Dental X-rays: Types of X-Rays

Extra-oral Radiographs

These x-rays focus on the jaw and skull. Although the dentist can see the teeth, these x-rays are used to detect cysts, abscesses, masses, and impacted teeth, as well as any problems with the bones in the face, sinuses, temporomandibular joint (TMJ), or jaw joint.

Types of extra-oral x-rays that we may take in our office:

PANORAMIC: shows the entire mouth area. Useful for seeing the position of teeth, detecting impacted teeth, and aid in the diagnosis of tumors.

CEPHALOMETRIC: shows the entire side of the head. Used to examine the relationship of the teeth to the jaw and patient's profile. Helps orthodontists create a treatment plan.

Intra-oral X-rays

These are the most common types of x-rays taken in the dental office. These are smaller, detailed x-rays that allow the dentist to check for cavities, see under the edge of fillings and/or crowns, and check the health of the bone and roots of teeth.

Types of intra-oral x-rays that we may take in our office:

BITEWING: shows the top part of the tooth and the supporting bone. Used to check between teeth for cavities, determine the fit of a crown, and status of existing fillings.

PERIAPICAL: shows the entire tooth and bone below the root. Useful in detecting abnormalities of the roots or bone anchoring a tooth to the jaw.

Dental X-rays: Radiation

Modern techniques and equipment allow dental offices to minimize the radiation exposure from dental x-rays to almost negligible amounts. This allows us to safely take x-rays on both adults and children. However, to protect you from the low levels of radiation emitted from x-rays, our office uses a lead apron to prevent radiation exposure to your vital organs.

To see how the amount of radiation from dental x-rays compares to other sources, please see the chart below.

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All Radiation Doses are in millisieverts (mSV)		
	0.00005	Sleeping next to someone, for 1 year
	0.00010	Eating 1 banana
	0.00025	Airport security body scanner
	0.00500	**1 Bitewing or Periapical dental x-ray**
	0.01000	**1 Panoramic dental x-ray**
	0.04000	Flight from New York to Los Angeles
	0.07000	Living in a brick/stone/concrete house for 1 year
	0.10000	Chest x-ray
	0.40000	Eating food for 1 year
	0.42000	Mammogram
	12.00000	Full body CAT scan
	36.0000	Smoking 1.5 packs of cigarettes everyday for 1 year
	80.0000	6 months on the international space station

Data obtained from the American Dental Association, International Atomic Energy Association, National Aeronautics & Space Association

Please inform our office staff if you are pregnant or think you may be pregnant before we take X-Rays.

Patient Name:_____ Date:_____

Signature:_____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name:_____ Date:_____

Signature:_____

What to expect at your first visit and the different types of dental cleanings.

I understand that my treatment today may include the following:
- Taking of radiographs (X-rays)
- Recording of periodontal probe depth measurements to check gum health and to assess which type of cleaning is needed.
- Removal of plaque and calculus with a metal instrument and/or ultrasonic scaler
- Coronal polishing
- Oral irrigation of gingival pockets
- Flossing of teeth
- Application of fluoride
- Oral cancer screening and dental exam

The benefits of fluoride are:
- Prevents formation of new cavities
- Remineralizes damaged tooth structure
- Prevents further breakdown of tooth structure in an acidic environment

Types of Cleanings

Prophylaxis (**Prophy**) cleaning or healthy mouth cleaning is diagnosed by the doctor when:
- Minimal or no gingival inflammation (gingivitis)
- Minimal or no calculus (plaque present)
- Probing depths are 1-3 mm
- Minimal or no bone loss
- Minimal or no calculus below the gum line.

Deep Cleaning or Scaling and Root Planing (SRP) is diagnosed by the doctor when one or more of the following is/are present:
- Gingivitis is present on many teeth
- Calculus is visibly present above and/or below the gum line.
- Probing depths of 4 mm or greater
- Radiographic bone loss is present on some or all teeth
- Radiographic calculus
- Bleeding when probing

The goals of dental cleanings are to eliminate any further damage to the periodontium (bone, gums, ligaments) that supports the teeth, prevent tooth loss, eliminate harmful toxins/bacteria, remove infection, eliminate bad breath, and restore overall oral and systemic health.

Patient Name:_____ Date:_____

Signature:_____