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FAMILY DENTAL

New Patient Information

Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If you have any questions, do not hesitate to ask.

Patient Name _____ Date of Birth ___/___/___
Gender _____ Pronounced _____
Address _____
City _____ State _____ Zip _____

Home # _____ Cell # _____
Work # _____ Email _____
Preference for confirming appointments:
Cell ☐ Home ☐ Work ☐ Email ☐

Spouse's Name _____ Date of Birth ___/___/___
Child _____ Date of Birth ___/___/___
Child _____ Date of Birth ___/___/___
Child _____ Date of Birth ___/___/___

Dental Insurance
Subscriber _____ Date of Birth ___/___/___
Primary Dental Insurance _____Group # _____
SS #/ID# _____ Employer_____
Secondary Dental Insurance _____ Group # _____
SS #/ID# _____ Employer _____

Name of previous dentist _____ Date of last dental visit ___/___/___
Premed _____ Allergy _____
Referred by _____

Patient Acknowledgment:

- I understand that all charges and copays incurred are due in full at the time of service.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

Please e-mail (mooresmilesdds@gmail.com), fax (608)782-4111, mail, or drop off this form prior to your appointment.

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Dental Health History

	Yes
Does your jaw make noise that bothers you or others?	☐
Do you clench or grind your jaw?	☐
Have you had problems with previous dental treatment?	☐
Do you gag easily?	☐
Do you wear dentures?	☐
Does food catch between your teeth?	☐
Do you have difficulty chewing food?	☐
Do your gums bleed easily?	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐
Are your teeth sensitive?	☐
Are you dissatisfied with the appearance of your teeth?	☐

How often do you brush? _____

How often do you floss? _____

What kind of toothpaste do you use? _____

Approximate date of last cleaning

_____

Name of your previous dentist/location

_____

Have you had dental treatment by a specialist in the past?

If yes, please list the specialist's name/procedure (oral surgeon, periodontist, endodontist, ect.)

_____

_____

_____

Treatment Goals

_____

_____

_____

Anything else you would like the hygienist/dentist to know:

_____

_____

_____

Please note: We feel each patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us at least 48-hour notice.

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Medical Health History

Patient Name _____ **D.O.B.** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. PLEASE PRINT.

Physician's Name _____ Most recent visit _____

Have you ever been hospitalized or had a major operation? ☐YES ☐NO
If yes, please list with approximate date:

_____

_____

Have you ever had a serious head or neck injury? If yes, explain. ☐YES ☐NO

_____

_____

Do you use, or have you used tobacco? ☐CURRENTLY USE ☐PAST USE ☐NO

If yes, type: (circle) cigarettes snuff/chew cigar pipe

How much per day? _____ Years of use _____

Do you take, or have you ever taken, Phen-Fen or Redux? ☐YES ☐NO

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐YES ☐NO

Do you pre-medicate prior to dental appointments? ☐YES ☐NO

Please list all: Prescription medications, herbal medications, and vitamins or supplements that you are currently taking.

Name of medication Dosage Condition/Reason you are taking

_____

_____

_____

_____

_____

Are you on a special diet? If yes, what kind? ☐YES ☐NO

_____

Are you currently pregnant? ☐YES ☐NO if yes, expected delivery date _____
Are you nursing? ☐YES ☐NO
Taking oral contraceptives? ☐YES ☐NO
Do you take Fluoride supplements? ☐YES ☐NO

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Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Erythromycin ☐ Latex
☐ Barbiturates ☐ Sulfa Drugs ☐ Local Anesthetics

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

Autism	☐	Fainting Spells/Dizziness	☐	Thyroid Disease	☐
AIDS/HIV	☐	Frequent Cough	☐	Tumors or Growths	☐
Alzheimer's Disease	☐	Frequent Diarrhea	☐	Ulcers	☐
Anaphylaxis	☐	Frequent Headaches	☐	Venereal Disease	☐
Anemia	☐	Low Blood Pressure	☐	Radiation Treatments	☐
Angina	☐	Lung Disease	☐	Recent Weight Loss	☐
Anxiety	☐	Mitral Valve Prolapse	☐	Renal Dialysis	☐
Arthritis/Gout	☐	Osteoporosis	☐	Rheumatic Fever	☐
Artificial Heart Valve	☐	Pain in Jaw Joints	☐	Rheumatism	☐
Artificial Joint	☐	Parathyroid Disease	☐	Scarlet Fever	☐
Asthma	☐	Psychiatric Care	☐	Shingles	☐
Blood Disease	☐	Hemophilia	☐	Sickle Cell Disease	☐
Blood Transfusion	☐	Hepatitis A	☐	Sinus Trouble	☐
Breathing Problems	☐	Hepatitis B or C	☐	Spina Bifida	☐
Bruise Easily	☐	Herpes	☐	Stomach Disease	☐
Glaucoma	☐	High Blood Pressure	☐	Stroke	☐
Hay Fever	☐	High Cholesterol	☐	Cancer	☐
Heart Attack/Failure	☐	Hives or Rash	☐	Chemotherapy	☐
Heart Murmur	☐	Hypoglycemia	☐	Chest Pains	☐
Heart Pacemaker	☐	Irregular Heart Beat	☐	Cold Sores/Blisters	☐
Heart Disease	☐	Kidney Problems	☐	Convulsions	☐
Cortisone Medicine	☐	Leukemia	☐	Congestive Heart Disorder	☐
Diabetes	☐	Sensory Disorder	☐	Congenital Heart Condition	☐
Drug Addiction	☐	Epilepsy/Seizures	☐	Tuberculosis	☐
Easily Winded	☐	Excessive Bleeding	☐	Tonsillitis	☐
Excessive Thirst	☐	Yellow Jaundice	☐	Parkinson's disease	☐
Emphysema	☐	Liver Disease	☐	Depression	☐

Do you have a medical condition not listed that we should know about? ☐YES ☐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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature _____Date_____
Parent or Guardian signature if a minor

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Informed Consent for Dental Treatment in the Era of COVID-19

Thank you for your continued trust in our practice as with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “Coronavirus”, at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. “Social Distancing” nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distance between the patient, dentists, and dental staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No_____

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

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Authorization for Release of Records

Name of Patient_____ **Date of Birth**_____

I hereby consent to and authorize_____
to disclose information from my healthcare record relating to my identity, diagnosis, prognosis or treatment to:

Mooresmiles Dental
1630 Losey Boulevard South, La Crosse, WI 54601
E-mail: mooresmilesdds@gmail.com

Information to be disclosed:
____ Health History Form (includes insurance, medical history and medication information)

____ Diagnosis and therapeutic information (includes all examination and surgical records)

____ X-Rays (please send digital file in Dexis or jpg format to mooresmilesdds@gmail.com)

I understand that I have a right to inspect and receive a copy of the material that is disclosed as provided by the Wisconsin Administrative Code.

I understand that this consent is revocable.

Patient Signature_____ Date_____

Parent/Guardian_____

Relationship to Patient_____

NOTE: To ensure we provide comprehensive care for our patients, our office prefers to email digital radiographs and receive digital radiographs via email. Thank you.

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Authorization for Release of Identifying Health Information

Patient Name _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature:_____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name/Relationship to Patient: _____

Source of Authority:_____ Date:_____