PATIENT INFORMATION (CONFIDENTIAL)

Full Name: (Last)_____(First)_____(M.I.)___ What would you like us to call you?: _____ Sex: ❑M ❑F

Street Address:_____ City:_____ State _____ Zip _____

Birthdate:_____ Social Security # _____ Driver's License # _____Marital Status: _____

Home Phone: ❑ _____ Work Phone: ❑ _____ Mobile: ❑ _____

Please Check Your Preferred Contact Number

E-mail Address: _____

Employer Name (Patient/Parent's): _____

Employer's Address: _____

How did you find our practice? ❑Google ❑Yelp ❑Facebook ❑Website ❑Location/Drive by ❑Other: Please Specify_____

Previous Dentist:_____Date of Last Dental Visit:_____

To help us make your visit more comfortable, please let us know the following about your previous dental visits:

What you liked most:_____

What you liked least:_____

Please rate your smile: 1 2 3 4 5 6 7 8 9 10 (1 =worst 10 =best)

Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10 (1 =worst 10 =best)

What do you value most about your teeth?

	Cosmetic – You most value how your teeth look
	Function – You must value an ability to enjoy your favorite food and drinks
	Comfort - You must value NOT being in pain or having tooth or gum sensitivity
	Longevity - You must value the ability to have your natural teeth as long as possible

What is the most important objection or obstacle you have to visiting a dentist?

	No objections or obstacles - I come every 6 months and value my dental health
	Fear - I have a fear of pain, noises, environment and/or past experiences
	Time - I have a tight & busy schedule. I value convenient times.
	Have NOT had a sense of urgency - Nothing really hurts or I am able to live with pain
	No trust - I did not feel the treatment made sense nor did the dentist understand me

Yes	No	**Dental History**
		Are your teeth sensitive to hot or cold liquids/foods?
		Do you feel pain in any of your teeth?
		Do you have any sores or lumps in or near your mouth?
		Have you had any difficult extractions in the past and/or prolonged bleeding?
		Do your gums bleed when you brush?
		Do you have an unpleasant taste or odor in your mouth?
		Do you have any fillings or discolored teeth that show when you smile?
		Is there anything about the appearance of your teeth that you would change? (What?)

I authorize Palm View Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Name: _____

Signature of patient (or parent if patient is a minor) ***Date***

HEALTH INFORMATION

Medical Physician: _____Office Phone_____Last Visit_____

Are you under medical care now? (If so, please describe) _____

Please list any medications you are taking (including non prescription): Med 1 _____ Med 2_____

Med 3 _____ Med 4_____ Med 5_____ Med 6_____ Med 7 _____

Do you use tobacco products? (Re: cigarettes, smokeless tobacco)_____

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medications and treatments are best for you. **(Be sure to fill chart out completely.)**

If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.

Yes	No		Yes	No	
		Diabetes			Organ Transplant *
		Kidney Dialysis *			Joint Replacement and/or Implant *
		Rheumatic Fever *			Radiation Treatment
		Heart Murmur *			Stroke
		Valve Disorders *			Anemia
		Heart Trouble, Heart Attack			Frequently Tired or Easily Winded
		Heart Disease			Liver Disease
		Chest Pains			Hypo or Hyper Thyroid (Please specify)
		Cardiac Pacemaker			Ulcers, Stomach or Mouth
		High or Low Blood Pressure (Please specify)			Respiratory Problems, Tuberculosis
		Asthma			Eye or Ear Problems
		Hepatitis (Specify A, B or C) Year:			Epilepsy or Seizures
		Frequent Illness, Lowered Immunity			Venereal Disease, any type
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + or AIDS
		Cancer, Tumors, Cysts			Other

Allergies

Yes	No		Yes	No		Please list any other allergies:
		Penicillin			Iodine	
		Local Anesthetics			Latex Rubber	
		Aspirin			Sulfa Drugs	
		Codeine			Acrylic	

Is there any other health information we should know?

Are You Pregnant? ❑ YES ❑ NO Due Date: _____Nursing? ❑ YES ❑ NO Oral Contraceptives? ❑ YES ❑ NO

(Please inform us if you become pregnant.)

Please inform us if your health information should change in any way.

Whom should we contact in case of an emergency? **(Please do not leave this blank)**

Name:_____Phone:_____Relationship?_____

Closest relative or friend not living with you? _____Phone: _____

To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.

Signature of patient or parent: _____Date:_____

TREATMENT TO BE DONE

1. DRUGS AND MEDICATION:

I understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **(Initials _____)**

2. CHANGES IN TREATMENT PLAN:

I understand that during treatment, it may be necessary to change or add procedures due to conditions found whole working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions necessary. **(Initials _____)**

3. REMOVAL OF TEETH:

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the recommended teeth and any other necessary due to a change in treatment plan. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissues (Paresthesia) that can last for an indefinite period of time (days – months, or in rare cases, permanently) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **(Initials _____)**

4. CROWNS, BRIDGES, AND VENEERS:

I understand sometimes it's not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns which may come out easily. And I must be careful to ensure that they are kept on until the permanent prosthesis is delivered. I realize the final opportunity to make changes in my new crown, bridges, cap, (including shape, fit, size, and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crown, bridge, cap, it may not fit properly. And I will be responsible for any lab fees incurred if a remake becomes necessary. **(Initials _____)**

5. DENTURES, COMPLETE OR PARTIAL:

I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, & possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the teeth and wax try-in visit. I understand most dentures require relining approximately 3-6 months after initial placement and yearly thereafter. The cost of these relines is not included in the initial denture fee. **(Initials _____)**

6. ENDODONTIC TREATMENT (ROOT CANAL):

I realize there is no guarantee that root canal therapy will save my tooth, and complications can occur (such as infection) from the treatment. I further realize that occasionally root canal filling material may extend through the root or it may not be possible to completely fill the root which does not necessary affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). **(Initials _____)**

7. PERIODONTAL LOSS (TISSUE AND BONE) :

I understand that I have a serious condition and my dentist has advised me to have a consultation with the Periodontist. I understand that not undertaking periodontal treatment may have an adverse affect on my periodontal condition and could lead to the loss or some or all of my teeth. **(Initials _____)**

8: SEALANTS/SPACE MAINTAINER:

I realize that there is no guarantee with the application of a sealant or sealants on my child depending on the child's hygiene, sealants may dissolve or break away from the tooth causing possible decay. I understand that a space maintainer is a fixed appliance. I further understand that I am fully responsible to have the appliance checked every 6 months. **(Initials _____)**

10. FILLING/BONDING:

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common aftereffect of a newly placed filling. **(Initials _____)**

I understand that dentistry is not an exact science, and therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. **(Initials _____)**

Signature:_____ **Date:**_____

Palm View Dental: Appointment & Financial Policy

We are committed to providing you and/or your child with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: **Cash, Check, Visa or Mastercard.**

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contact negotiated between you or your employer and the plan. We are happy to help our patients or parents and guardians of our patients with dental benefit plans to understand and maximize their coverage. **We cannot guarantee any estimated coverage. You will be responsible for all charges not covered by your insurance plan.**

Our practice **IS / IS NOT** (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount will be billed and you will be responsible for the difference.
If we are not a contracted provider with your dental benefit plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us.

Statements and Collections – You will receive statements from our office. If you are not able to clear your balance in 30 days from the date of service, an arrangement will need to be made with our business manager to pay the balance. Accounts not paid or maintained on a current basis after 90 days will be subjected to collection action. Any account past due will be subjected to a finance charge of 18% annum added to the bill. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all cost of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

Appointment Policy: We understand your time is valuable, as is ours. Our doctors reserve time in their schedules just for you. Therefore, we require a 48-hour notice of cancellation or reschedule for all appointments. A fee of $50.00 will be applied to each appointment time missed and we may require a $50.00 deposit to reserve future appointments if appointments have been repeatedly missed. It is the patient's responsibility to be aware of his or her scheduled appointments. If the correct information is provided, a reminder email, text, and/or call will be sent to you as a courtesy. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen (15) minutes late or more arriving to our practice.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I or my child may need and have consented to during diagnosis and treatment. (initial) _____

I have read the above and agree to the Financial and Appointment policies (initial) _____

I authorize the release of information necessary to process my dental benefit claims.
I hereby authorize payment directly to this doctor otherwise payable to me. (initial) _____

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial) _____

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) _____

_____ _____
Print Name of Responsible Party Date

_____
Signature of Responsible Party