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Dental History

Name_____ **Date**_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

What is your primary reason for coming here? _____

When was your last dental visit? _____

Do any of the following hurt your teeth? Hot ❑ Cold ❑ Sweets ❑ Chewing ❑

How often do you brush your teeth? _____ Do your gums bleed when you brush your teeth? _____

Does your partner say you snore loudly and stop breathing during the night? _____

Do you drink alcohol or smoke? _____

Is your neck size greater than 171/2 inches (for a man) or 15 inches (for a woman)? _____

Are you often sleepy during the day, or do you fall asleep during inappropriate times such as at work or while driving?
_____

Do you clench or grind your teeth? _____

Do your jaws click or pop? _____ how long? _____

Do you have frequent headaches? _____ Earaches? _____

Can you chew on both sides of your mouth? _____

Have you ever had braces on your teeth? _____ When? _____

Do you usually have many cavities? _____ Broken fillings? _____

Do you have any loose teeth? _____ Broken teeth? _____

Do you notice any wear to your teeth? _____ Food traps? _____

Do you have any restorations you are not happy with? _____

How do you feel about the appearance of your smile? _____

Is there anything in particular we can do to make your visits more pleasant? _____

_____

Please add anything you feel is important: _____

_____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	HIV+ AIDS
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

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HIPAA Privacy Form

Consent for Use and Disclosure of Health Information

You may refuse to sign this acknowledgement.

Purpose: This form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry on treatment, payment activities, and healthcare operations as described fully in our Notice of Privacy Practices.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations; and the use and disclosure regarding your protected health information. A full copy of our notice is available at our front desk. We are happy to provide a copy for your review and you may keep it if you wish. We encourage you to read it carefully before signing.

We reserve the right to change our privacy practices. You may obtain a copy of our Notice of Privacy Practices, including any revisions to our notice, at any time by contacting our office. Phone 863.665.6201 or johnpauldentist@aol.com.

Right to Revoke: You have the right to revoke this consent at any time by submitting written notice of your revocation to this office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue to treating you if you revoke this consent. At your request we will provide a revocation of consent for you to sign.

I have had full opportunity to read and consider the contents of this form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am authorizing your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of Responsible Party	Relationship to Patient	Date

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Agreement to Receive Electronic Communication

Patient Name _____ Date of Birth _____

(*Initial Below*)

_____I Agree

_____I Do Not Agree

That the dental practice may communicate with me electronically at the email address and/ or mobile phone number listed below.

I am aware there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any update to my email address and/ or mobile number.

My preferred method of electronic communication:

(*Initial below*)

____ Text Messaging

____ Email

I would like to receive:

____ Appointment Reminders / Recall Visits

____ Information regarding insurance and billing

____ Requests for online patient satisfaction reviews

I can withdraw my consent to electronic communications at any time by calling:

Dr. John Paul 863.665.6201

Patient signature: _____ Date _____

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General Payment Agreement

Patient Name: _____

Agreement:

I agree that I am responsible for all services rendered to the patient and that payment is due and payable to the practice at the time services are rendered unless there is another specific signed financial arrangement different from this general agreement. I understand that health, dental, and accident insurance policies are an arrangement between my insurance carrier and me, and that Dr. Paul is not a contracted provider with any private insurance company or Medicare/ Medicaid. I understand that while the practice will file claims with my insurance company on my behalf, I remain responsible for any amount not paid by my insurance company. I also understand if the practice cannot verify my insurance benefits eligibility I will pay in full for services at the time they are rendered or I will make a payment agreement with the practice before services are rendered. I understand the practice may charge 1) a fee for failing or canceling an appointment without 1 business day notice 2) a late fee if payment is not received by the due date and 4) a fee of at least $35 and as much as allowed by law for each returned check. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize all third party payors to make payments directly to the practice.

Responsible Party:

Full Name: _____ DOB: _____

Street Address _____ City_____ State ____ Zip _____

Primary Phone _____ Second Phone _____

If You Plan to Use Insurance:

Company Name: _____ Address _____ Phone _____

Name of Insured_____ Relationship_____ SSN _____

Group number _____ ID number _____

I acknowledge that I have had the opportunity to review the office Notice of Privacy Practices and to have a copy for my files if I so choose. I agree that a photocopy of this authorization is as valid as the original.

Signature of responsible party: _____ Date _____

To be signed even if the patient is the responsible party

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For our patients that utilize dental benefits/ third party payors:

Due to the increase in the amount of time it takes dental insurance companies to reimburse our office for services performed we want you, the patient, to know that we will no longer be able to wait indefinitely for payment.

We will continue to submit your insurance claims, after you have paid your deductible and co-pay, if applicable; however we will only wait 45 days for reimbursement. After that time the full responsibility of your balance will be yours.

We will do everything possible to assist you in obtaining your refund from your insurance company. If you need insurance forms, x-rays etc. you only need to ask.

I have read and understand the above information and I agree to pay my balance after 45 days if the insurance has not paid their portion.

Signature_____Date_____