Hope DENTAL PROFESSIONALS

Today's Date_____ **How did you hear about our office?**_____

Patient Name Mr. Ms._____ **Preferred Name** _____ **Date of Birth**_____

Address _____**Apt #**_____ **City** _____ **State**_____ **Zip**_____

Phone (H) _____ **(Work)** _____ **ext**_____ **(Cell)** _____

Best time and place to reach you_____ **email address** _____

Social Security _____ **Gender: M or F** **Are You: Single Married Divorced Separated Widowed**

Place of employment_____**Occupation**_____

Insurance Information_____

Spouse/Parent/Guardian Information:

Name Mr Ms._____ **Preferred Name** _____ **Date of Birth**_____

Address _____**Apt #**_____ **City** _____ **State**_____ **Zip**_____

Phone (H) _____ **(Work)** _____ **ext**_____ **(Cell)** _____

Best time and place to reach you_____ **email address** _____

Social Security _____ **Gender: M or F** **Are You: Single Married Divorced Separated Widowed**

Place of employment_____**Occupation**_____

Emergency Contact Information: **Person not living at your residence.**

Name Mr Ms._____**Relationship to patient**_____**Phone (H)** _____

Address _____**Apt #**_____ **City** _____ **State**_____ **Zip** _____

Hope DENTAL PROFESSIONALS

Medical History

Patient Name_____ Date of Birth_____

Name of Physician_____Last physical _____

1. **Are you in good health? Yes□ No□ _____**
2. **Do you smoke/use smokeless tobacco Yes□ No□ How much?_____**
3. **Do you drink alcohol? Yes□ No□ How often?_____**
4. **Do you currently or have you ever used illegal drugs or have a chemical dependency Yes□ No□**
5. **Are you currently under the care of a physician? Yes□ No□_____**
6. **Have you been Hospitalized or had a major operation? Yes□ No□ _____**
7. **Have you ever had a serious neck or head injury? Yes □ No □ _____**
8. **Medications you are currently taking, including over the counter and vitamins:**

   _____ _____mg How often_____
   _____ _____mg How often_____
   _____ _____mg How often_____
   _____ _____mg How often_____
   _____ _____mg How often_____

9. **Do you require an antibiotic prior to treatment? Yes□ No□ _____**
10. **Have you ever taken Phen-Fen/ Redux? Yes□ No□ Biophosphonate? Yes□ No□**
11. **Do you take an Aspirin every day? Yes□ No□**

Women only: Are you pregnant/nursing? Yes□ No□ Are you taking oral contraceptives? Yes□ No□

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Metal □Latex □Local anesthetics □Sulfa □Other_____

_____

Do you have or have a history of the following?

□AIDS/HIV positive	□Fainting or dizziness	□Rheumatic fever
□Anemia/Blood disorder	□Glaucoma	□Scarlet fever
□Arthritis/Gout	□Headaches	□Sinus trouble
□Artificial Heart valves/joints	□Heart murmur	□Skin rash
□Asthma	□Hepatitis Type_____	□Special diet
□Back problems	□High/Low blood pressure	□Stroke
□Bleeding problems/disease	□High cholesterol	□Swollen feet or ankles
□Cancer	□Kidney disease	□Swollen neck glands
□Chemotherapy	□Liver disease	□Thyroid problems
□Circulatory problems	□Mitral valve prolapse	□Tonsillitis
□Cold sores/fever blisters	□Osteoporosis	□Tuberculosis
□Cortisone treatment	□Pacemaker	□Tumor or growths
□Diabetes	□Psychiatric/Nervous Problems	□Ulcers--stomach
□Emphysema	□Radiation treatment	
□Epilepsy/convulsions	□Respiratory disease (breathing troubles)	

Patient Signature_____Date_____

Doctor Signature_____Date_____

Hope DENTAL PROFESSIONALS

Dental History

Patient Name_____ Date of Birth_____

Previous Dentist _____ Address _____ Phone _____

Last visit _____ Reason for that visit _____ how often do you get your teeth cleaned

Please answer the following questions:

1. **Do your gums bleed……Yes No**
2. **Do you have bad breath……..Yes No**
3. **Do you experience sensitivity to cold, hot, sweets, or pressure……...Yes No**
4. **Do you have sore teeth……Yes No**
5. **Do you have a bad taste in your mouth……Yes No**
6. **Do you have periodontal disease / treatment…….……Yes No**
7. **Do you a burning sensation in your mouth……...Yes No**
8. **Do you have difficulty swallowing……..Yes No**
9. **Do you have popping or clicking in your jaw……Yes No**
10. **Do you have dry mouth, throat or eyes……..Yes No**
11. **Do you have jaw problems……...……Yes No**
12. **Do you clench or grind your teeth……...Yes No**
13. **Do you have missing any teeth……Yes No**
14. **Are you unhappy with the appearance of your teeth……Yes No**
15. **Have you used bleaching products…….……...……..Yes No**
16. **Did you have orthodontia (braces)……...…Yes No**
17. **Does food collect between your teeth…….....Yes No**
18. **Are you a mouth breather……...….Yes No**
19. **Do you chew on one side of your mouth……..…...Yes No**
20. **Do you bite your fingernails……...……Yes No**

How do rate your current dental health? _____ Excellent _____ Good _____ Fair _____ Poor
How often do you brush _____morning _____ night _____ both
What kind of toothbrush do you use? ____ Manual ____ electric
How often do you floss? _____ Daily _____ weekly _____ occasionally _____ never

Health and Nutrition:
Do you_____ Eat Breakfast _____Drink Coffee _____Drink soda–how many a day
Exercise:_____ Light_____ Moderate _____ Heavy
Quality of sleep _____ Level of stress at work or home _____

Comments, concerns or other information pertinent to today's appointment _____

_____

Patient/ Guardian Signature _____Date_____

Doctor Signature _____ Date _____

Hope DENTAL PROFESSIONALS

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies
(Adult)

I have received a copy of the Notice of Privacy Practices of Hope Dental Professionals. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name Address

_____ _____
Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

5._____Date Added / Removed: _____

*** * ***

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Hope DENTAL PROFESSIONALS

Understanding Your Dental Insurance

At Hope Dental Professionals, we strive to give the highest quality service. A part of that service is to help you understand how your insurance works and estimate your part of the investment in your dental health.

It is important that you know that we are here to **partner with you** in understanding your dental insurance coverage to better help you maximize this benefit. In order to do this, we request you bring a copy of your insurance book, which you should have received when your benefit began. This will allow us to give you the best possible estimate and to better help you determine what exclusions and clauses are in your plan.

Some of the insurance companies we deal with do not always give information regarding their fees, and all of them do not guarantee benefit quotes (even with a predetermination). Your insurance plan is an agreement between you and the insurance company not between our office and the insurance company, so they are not obligated to give our office any information. Also, there are no regulations as to how insurance companies determine reimbursement, resulting in wide fluctuation. **Because of these practices, our estimates of your portion owed is an estimate and not a final quote. As a service to you we allow a 45 day grace period for your insurance to pay before it becomes your responsibility.**

I have read the above information, understand and agree to the conditions of the content.

Patient/Signature_____Date_____

I hereby authorize payment directly to the office of Hope Dental Professionals the insurance benefit otherwise payable to me. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance after 45 days regardless of my insurance, and that I am responsible for any attorney, collection and interest fees regarding collection of outstanding balances including 1.5% / month or 18 %/ year interest if my balance goes unpaid past 90 days regardless of my insurance. Hope Dental Professioanls is not part of any court arrangement you may have for payment in regards to divorce ,custody or other and the person signing below agrees to guarantee payment. I hereby authorize the staff of Hope Dental Professioanls to administer such medications and perform such diagnostic, photographic (including X-Rays and study models) and therapeutic procedures as may be necessary for proper diagnosis and dental treatment. The information on these pages including but not limited to the dental and medical histories as well as general demographics are correct to my best knowledge. I grant the right to Hope Dental Professionals to release my Medical/dental histories and other information about dental treatment to third party payers and /or other health professionals.

Patient / Guardian Signature _____ Date_____

Informed Consent- General Consent for Treatment

I understand that all dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- **Drug reactions and side affects**
- **Damage to adjacent teeth or fillings**
- **Post-operative infection**
- **Post-operative bleeding that might require treatment**
- **Delayed healing of an extraction site, (dry Socket) necessitating additional care**
- **Sinus involvement during removal of upper molars which require additional treatment or surgical repair at a later date**
- **Involvement of nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas**
- **Bruising, swelling, sensitivity or pain**
- **Failure of a dental procedure necessitating additional treatment**
- **Breakage of dental interments inside the tooth canals making additional treatment necessary**
- **Complications during treatment necessitating referral to a specialist**

I understand the recommended treatment for my condition(s), the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fees involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

My signature also confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers for my health care services**
- **Conduct normal health care operations such as quality assessment and improvement activities**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian Signature_____Date_____

Witness_____Date_____

Office Use Only

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□Individual refused to sign
□Communication barriers prohibited obtaining the acknowledgment
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