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Dental History

Patient Name: ____

Reason for today's dental visit: _________________________________ Date of last dental visit: __________________

Please check any of the following problems that may apply to you.

- Nervousness **Yes / No**
- Jaw Joint pain Yes / No
- Teeth or fillings breaking Yes / No
- Grinding or clenching teeth Yes / No
- Bleeding, swollen or irritate gums Yes / No
- Loose, tipped or shifting teeth Yes / No
- Bad breath or bad taste in your mouth Yes / No
- Sensitivity: Hot / Cold/ Sweets / Pressure/None

If you could whiten your teeth for a cost anyone could afford, would you do it? **Yes / No**

If I could change my smile, I would:

- Make them brighter Yes / No
- Make them straighter Yes / No
- Close spaces Yes / No
- Replace black metal filling with natural Yes / No
  tooth-colored fillings Yes / No
- Repair chipped or missing teeth Yes / No
- Replace old crowns that don't match Yes / No

On a scale of 1 – 10, with 10 being the highest rating:

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

____

____

What is the most important thing to you about your future smile and dental health?

____

____

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PATIENT INFORMATION:

Date:_______________ Whom may we thank for referring you?____________________________

Patient's Name:____SS#__________________
Last First Middle Initial

I prefer to be called: ___________________________

Is there an existing family member's account you wish to be added to?
If so, who _________________________________

Address: ____

City: _________________________ State:________ Zip Code:___________________

Home #:______________________ Cell#:____________________ Work#:_____________________

Email: ____

As a courtesy, we offer appointment confirmation via email, text message or phone.
Please inform us of your preference:
Email Text Home Phone Work Phone Cell Phone

Sex: **M / F** Date of Birth___________ Single Married

Employer: _________________________________ Occupation:___________________________

Emergency Contact:___________________________ Contact #:_______________________

INSURANCE/RESPONSIBLE PARTY: *Relationship to Patient*: ___________________

Subscriber:____
Last First Middle Initial

SSN: ________________________ Date of Birth: _________________

Employer:___________________________________

Dental Plan Name:_____________________________

Dental Plan Address:____

Insurance Phone #: ____________________ Group #:_______________ Employee ID#:________________

How did you hear about us? Please mark below:

- □ Office Sign □ Dental Team Member □ Friend / Relative □ Insurance □ Flyers / Mail
- □ Health Fairs □ Google □ Social Media □ Yelp □ Other

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THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient you have the following rights:

1.The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.
Please list all telephone numbers where we may contact you:

1. _____________________2.___________________ 3.____________________ 4.____________________

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name: ____Relationship:_______________________________
I authorize North Richardson Dentistry to Release my information including diagnosis and the records of any treatment or examination rendered any other healthcare practitioners as necessary for treatment and/or to third party payers.

X-Ray, Examination, & Cleaning Consent

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken of my teeth, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that, if I am pregnant, radiation exposure poses a serious threat to life and health of my unborn child. Pregnant women are required to have a medical release from their Medical Doctor prior to X-rays and Dental treatment. I understand that I will, if necessary, be receiving a dental cleaning by a state licensed dental practitioner and given oral hygiene instructions to help maintain proper health of the oral cavity.

Acknowledgment of Notice of Privacy Practice and Financial Responsibility

Appointment cancellations must be done more than 24 hours before scheduled appointment time. If the cancellation is made within 24 hours of your scheduled appointment, a cancellation fee in the amount of **$75.00** will be automatically charged to your account.

Please be advised that we cannot guarantee any estimates and that there may be a balance after insurance pays. Rarely does an insurance plan cover 100% of your dental treatment. We will do our best to estimate your deductible and insurance co-payment. However, any remaining balance is your direct responsibility. I agree to be responsible for payment of all services rendered on my behalf of my dependents. For your convenience, we accept cash, check and credit cards. We also offer extended payment plans through Care Credit financing.

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice and understand that the practice will offer me an updated copy to the Notice should it be amended, modified, or changed in any way upon my request.

Print Patient Name:___________________________

Signature of Patient or Legal Guardian:_______________________________________ Date:__________________

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MEDICAL HISTORY

Patient Name: ______________________________________ Preferred Name:_________________
Last First Middle
Physician's Name:_____________________________________ Office #: _____________________
Specialist's Name:_____________________________________ Office #: _____________________

Allergies

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Latex Aspirin Penicillin Codeine Acrylic Metal Local Anesthetics

NONE If other, please explain_______________________

Do you require a pre-operative antibiotic before dental treatment? yes no
If yes, reason____________________________

Medications	Dosage	Reason

PAST AND CURRENT MEDICAL CONDITIONS (*mark all that apply*)

□ Heart Disease	□ Heart Murmur	□ High Blood Pressure	□ Blood Disease	□ Rheumatic Fever	□ Venereal Disease
□ Heart Pacemaker	□ Tuberculosis	□ Diabetes	□ Scarlet Fever	□ Anemia	□ Kidney Trouble
□ Seizures	□ Ulcers	□ Emphysema	□ Pain in Jaw Joints	□ Asthma	□ Hay Fever
□ Nervousness	□ Thyroid Disease	□ Chemo: (Cancer)	□ Arthritis	□ Rheumatism	□ Bruise Easily
□ Cortisone	□ Glaucoma	□ HIV + AIDS	□ Hepatitis	□ Hemophilia	□ Sickle Cell Disease

□ **NONE**

Tobacco Use: **Yes / No**
Are you taking any oral Bisphosphonates? **Yes / No** Type:____
Do you take blood thinners? **Yes / No** Type:____
Have you had any joint replacements? **Yes / No**
If female, are you pregnant? **Yes / No** Months: _________
Are there any other conditions you feel the doctor should know about or would like to speak in private? YES NO

Signature of Patient, Parent or Guardian ______________________________________ Date: ________________

Medical History Update:

____________________________ ____________________________ ____________________________
Dr. Date Dr. Date Dr. Date