DREW DENTISTRY

Patient Full Legal Name: _____ Preferred Name to be Called: _____

Date of Birth: _____ Sex: M / F Social Security #: _____

Home Address: _____ City: _____ Zip Code: _____

Contact Numbers: (Home)_____ (Cell) _____

Email Address: _____

Spouse's Name: _____ Phone Number: _____

Emergency Contact (Name/Relationship): _____ Phone Number: _____

Employer Name: _____ Phone Number: _____

Do you prefer to be contacted via: Phone / Text / Email How did you hear about us? _____

INSURANCE INFORMATION

PRIMARY

Policy Holder Name: _____ Birthdate of Policy Holder: _____

Relationship to Patient: _____ Insurance Company Name: _____

Subscriber ID/Member ID: _____ Group/Policy #: _____

SECONDARY

Policy Holder Name: _____ Birthdate of Policy Holder: _____

Relationship to Patient: _____ Insurance Company Name: _____

Subscriber ID/Member ID: _____ Group/Policy #: _____

Assignment and Release

I hereby authorize(1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3)the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs and x-rays of my dental care treatment (collectively "my images"), and (5) my dentist's use of my images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form.

Patient/Parent/Guardian Signature: _____ Date: _____

DREW DENTISTRY

MEDICAL HISTORY

Name of Physician: _____ Contact #: _____

Date of most recent physical examination: _____ Purpose: _____

How is your overall general health? ____Excellent ____Good ____Fair ____Poor

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES/NO
1. Hospitalization for illness or injury _____	☐☐
2. An allergic reaction to	
_____Aspirin, ibuprofen, acetaminophen, codeine	
_____Penicillin	
_____Erythromycin	
_____Tetracycline	
_____Sulfa	
_____Local anesthetic	
_____Fluoride	
_____Metals (nickel, gold, silver, _____)	
_____Latex	
_____Other _____	
3. Heart problems, or cardiac stent within the last six months _____	☐☐
4. History of infective endocarditis_____	☐☐
5. Artificial prosthesis (heart valve or joints) _____	☐☐
6. High or low blood pressure (if yes please circle one)_	☐☐
7. Stroke (taking blood thinners) _____	☐☐
8. Anemia _____	☐☐
9. Prolonged bleeding due to slight cut _____	☐☐
10. Emphysema, shortness of breath, sarcoidosis _____	☐☐
11. Tuberculosis, measles, chicken pox _____	☐☐
12. Asthma _____	☐☐
13. Breathing or sleep problems (sleep apnea, snoring) __	☐☐
14. Kidney disease _____	☐☐
15. Liver disease _____	☐☐
16. Jaundice _____	☐☐
17. Thyroid, parathyroid disease, or calcium deficiency __	☐☐
18. Hormone deficiency _____	☐☐
19. High cholesterol or taking stain drugs _____	☐☐
20. Diabetes _____	☐☐

	YES/NO
21. Stomach or duodenal ulcer _____	☐☐
22. Digestive disorders (celiac disease, gastric reflux)	☐☐
23. Osteoporosis/osteopenia (on bisphosphonates)_	☐☐
24. Arthritis, rheumatoid arthritis, lupus _____	☐☐
25. Glaucoma _____	☐☐
26. Contact lenses _____	☐☐
27. Head or neck injuries _____	☐☐
28. Epilepsy, convulsions (seizures) _____	☐☐
29. Neurologic disorders (ADD/ADHD/prion disease)	☐☐
30. Viral infections or cold sores _____	☐☐
31. Any lumps or swelling in the mouth _____	☐☐
32. Hives, skin rashes, hay fever _____	☐☐
33. STI/STD/HPV __(if yes please circle one)_____	☐☐
34. Hepatitis (type_____) _____	☐☐
35. HIV/AIDS _____	☐☐
36. Tumors, abnormal growths _____	☐☐
37. Radiation therapy _____	☐☐
38. Chemotherapy, immunosuppressive _____	☐☐
39. Psychiatric treatment _____	☐☐
40. Alcohol/street drug use _____	☐☐
41. Presently being treated for any other illness ____	☐☐
42. Aware of a change in your health in the last 24 hrs (fever, chills, new cough, diarrhea)	
43. Often exhausted or fatigued _____	☐☐
44. Experiencing frequent headaches _____	☐☐
45. A smoker, smoked previously, smokeless tobacco, vape	☐☐
46. FEMALE – taking birth control _____	☐☐
47. FEMALE – pregnant/breastfeeding _____	☐☐
48. MALE – Prostate disorders _____	☐☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. _____

List all medications, supplements, and/or vitamins taken within the last two years and the purpose: (use back side if needed)

_____

Patient/Parent/Guardian Signature: _____ Date:_____

DENTAL HISTORY

Name of Previous Dentist: _____ Contact #:_____
How is your overall dental health? ____Excellent ____Good ____Fair ____Poor
What is your immediate concern? _____

Please answer yes or no to the following questions

	YES/NO
1. Are you fearful of dental treatment? _____	☐☐
2. Have you had an unfavorable dental experience? _____	☐☐
3. Have you had complications from past dental treatment? _____	☐☐
4. Have you ever had trouble getting numb or had and reactions to local anesthetic? _____	☐☐
5. Have you ever had braces, orthodontic treatment? _____	☐☐
6. Do your gums bleed or are they painful when brushing and flossing? _____	☐☐
7. Have you ever been treated for gum disease or told you have bone loss? _____	☐☐
8. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐☐
9. Have you ever experienced gum recession? _____	☐☐
10. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐☐
11. Have you ever had any teeth become loose on their own without injury? _____	☐☐
12. Are any teeth sensitive to hot/cold, biting or sweets? _____	☐☐
13. Do you frequently get food caught between your teeth? _____	☐☐
14. Do you have any broken or chipped teeth? _____	☐☐
15. Do you feel your mouth is overly dry? _____	☐☐
16. Do you have problems with your jaw? (pain, popping, clicking, limited opening) _____	☐☐
17. Do you clench or grind your teeth or have you ever been told that you do? _____	☐☐
18. Do you wear or have you ever worn any type of mouth appliance? _____	☐☐
19. Have you ever felt uncomfortable or self-conscious about your teeth? _____	☐☐
20. Is there anything about the appearance of your teeth that you would like to change? (color, shape, length) _____	☐☐
21. Have you ever whitened (bleached) your teeth? _____	☐☐

Patient/Parent/Guardian Signature: _____ Date:_____

Acknowledgement of Privacy Policy

My signature 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 (HIPPA). 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 my 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 provider's *Notice of Privacy Practices* containing a more complete description of the use of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices.*

Patient/Parent/Guardian Signature: _____ Date:_____

Financial Policy

Insured Patients: It is your responsibility to provide us with your current dental insurance. We will provide you with an estimate for any treatment needs. Payment of your "estimated" portion is due at the time of service. We must emphasize that this will be an estimate only, not a guarantee of payment by your insurance company. Filing insurance claims is a courtesy we extend to our patients. We make every effort to follow up on unpaid claims, however, if we have not received payment after 60 days we ask that you discuss your claim with your insurance company. We cannot guarantee payment from your insurance company, as your coverage is a contract between you and your insurance. Any unpaid balance is your responsibility.

Non-Insured Patients: We will provide you with the total cost of treatment before it is completed, which is due in full at the time services are rendered, unless other satisfactory arrangements have been made. If payment is made in full with cash we do offer a 5% discount.

Payments: For your convenience we accept cash, checks, credit cards and Care Credit. If payment is returned from your bank a $35.00 dollar fee will be added to your account.

Past Due Accounts: Balances older than 60 days will be subject to a finance charge of 1.5% per month (18% annually). It will be added to the balance, along with a billing charge of $25. If the balance is still unpaid after 90 days, without contact with our office to make arrangements, the account will be turned over to a collection agency for further collection efforts.

Appointment Policy

We take pride in seeing patients in a timely manner; therefore, we ask that you arrive for your appointment on time. If you think that you will be late, please call our office as soon as possible so that we may advise you if your late arrival can be accommodated, or if we need to reschedule your appointment.

CONFIRMING APPOINTMENTS IS DONE AS A COURTESY. We ask that you remember your scheduled appointment. We will gladly call, text or send an email in advance as a reminder, please make sure we have updated contact information for you at all times.

WE REQUIRE 48 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT. Failure to provide 48 hour notice (2 business days) will result in a $75 charge per each scheduled hour of your appointment. The broken appointment fee must be paid before we will re-schedule you. If you acquire 3 broken appointments, we reserve the right to dismiss you as a patient.

An Appointment is considered broken for one or more of the following reasons:

- Arriving 15 minutes late to your scheduled appointment time
- Failure to show up for your scheduled appointment
- Rescheduling or canceling an appointment without giving 48 hours' notice

In our continuing efforts to provide quality dental services, we ask that you respect our appointment policy.

I have read, understand and agree to the above terms and conditions for the Appointment Policy and the Financial Policy.

Printed Patient/Parent/Guardian Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____

DREW DENTISTRY

Patient Photo Release

I, _____, hereby authorize Drew Dentistry or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, social media posts, etc.). I further understand that if the photographs, slides, and videos ae used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____ I do not mind if my photograhs are used in any of the above stated situations.

_____ I only agree to have my teeth shown without any identifying features.

Name _____ Date _____

Signature _____