New Patient Information

Name: ____ Date: ____________
Last First M Preferred

Birthdate: ___/___/___ Male ◯ Female ◯ Social Security# _____/_____/_____

Address: ________________________________ Cell Phone: ______________

City: ______________MI, Zip Code: __________ Home Phone: ______________

Marital Status: ◯ S ◯ M ◯ D ◯ W ◯ Under 18 Email: ______________________

Best time to reach me is: ______________ Phone to call: work, home, cell

Who can we thank for referring you to our office? ______________________________

Insurance and Financial Information: Do you have Dental Insurance? Yes ◯ No ◯
Insurance Name: ____________________ Employer: ____________________

Responsible Party: ____________ Subscriber's Name: ____________Phone: __________

Work address: ____________________ City: ________ Zip: ________ Phone: ________

Name of insured: ______________ D.O.B.____________ S.S.#____/____/____

Secondary Dental Insurance? No ◯ Yes ◯ ______________________________

Person we may contact in case of an emergency:

Name: ______________________________ Relationship: ______________________

Phone: ________________ Cell: ______________ Work Phone: ______________

Release Information:
You may discuss my care with: ________________________

Confirmations: Do you prefer a confirmation call: ◯ No, it is unnecessary ◯ YES, it is a helpful reminder

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Assignment & 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 she determines. 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 such uninsured cost in accordance with the office payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

______________________________________ ______________
Print name Date

______________________________________ ______________
Patient signature Date

MEDICAL HISTORY

Last Name: ____________________ First Name: ________________ Initial: ________

Birthdate: __________________ Cell: ________________ Home: ________________

Address: ______________________ City: ____________________ Zip: __________

List **ALL** medications, **ALL** Vitamins and what each is for:

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List ANY surgeries & dates:

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Physician's name: ______________________ Phone: __________________

Surgeon's name: ________________________ Phone: __________________

Emergency contact: ______________ Phone: ___________ Relationship to patient: ___________

Allergies:

- ☐ Acetaminophen
- ☐ Aspirin
- ☐ Codeine
- ☐ Clindamycin
- ☐ Darvon
- ☐ Demerol
- ☐ Erythromycin
- ☐ Epinephrine
- ☐ Foods: ______________________________
- ☐ Other Allergies______________________________
- ☐ Fluoride
- ☐ Hay fever
- ☐ Ibuprofen/Motrin
- ☐ IV dye
- ☐ Keflex
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Metals (nickel, gold, silver)
- ☐ Morphine
- ☐ NSAID
- ☐ Penicillin
- ☐ Seasonal
- ☐ Sulfa
- ☐ Tramadol
- ☐ Valium
- ☐ Xanax

Have you ever had any of the following? Check all that apply, Dates, Specifics:

- ☐ AIDS/HIV ______________
- ☐ Artificial Heart Valve _______
- ☐ Anemia ____________
- ☐ Arthritis ________________
- ☐ Anesthesia Problems ________
- ☐ Anxiety disorder
- ☐ Artificial Joints:
  - What: __________________
  - Date: __________________
- ☐ Asthma: Last attack _________
- ☐ Acid Reflux
- ☐ Autoimmune disease___________
- ☐ Blood thinners: _______________
- ☐ Blood Disease: _______________
- ☐ Boniva/Fosamax/Zometa/Aredia
- ☐ Cancer _______________
- ☐ ADD/ADHD _________
- ☐ Chemotherapy ________
- ☐ Chicken pox, measles, shingles____
- ☐ COPD
- ☐ Chew Tobacco
- ☐ Depression
- ☐ Diabetes HBA1c=____________
- ☐ Digestive Disorders ___________
- ☐ Dizziness/Fainting spells ________
- ☐ Dialysis ____________
- ☐ Excessive Bleeding
- ☐ Emphysema
- ☐ Glaucoma ____________
- ☐ Jaundice (Child/Adult: yr.___)
- ☐ Gastric Bypass surgery _________
- ☐ Lap band surgery_____________
- ☐ Natural remedies: ____________
- ☐ Oxygen _______________
- ☐ High Blood pressure (white coat)
- ☐ Head Injuries___________
- ☐ Heart Disease ___________
- ☐ Heart Murmur ___________
- ☐ Heart Valve Repair________
- ☐ Heart Attack ___________
- ☐ Hepatitis Type__________
- ☐ HPV
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Premedication
- ☐ High Cholesterol
- ☐ Low Cholesterol
- ☐ Hormone Deficiency
- ☐ Migraines
- ☐ Mitral Valve Prolapse_____
- ☐ Mental disorders______
- ☐ Multiple Sclerosis
- ☐ Nitroglycerin
- ☐ Pacemaker ______
- ☐ Implantable defibrillator ____
- ☐ Irregular Heartbeat
- ☐ Bipolar disorder
- ☐ Tumor/Abnormal growth
- ☐ Collagen Injections
- ☐ Botox __________
- ☐ Back Injury ____________
- ☐ Hypoglycemic
- ☐ Nervous Disorders _________
- ☐ Previous Infective Endocarditis
- ☐ Vertigo
- ☐ Rheumatic Fever _______
- ☐ Radiation Treatment _______
- ☐ Sinus Problems
- ☐ Snoring Problem
- ☐ C-PAP Machine
- ☐ Sleep apnea
- ☐ Smoker ______________
- ☐ Stents ________________
- ☐ Stomach Ulcers
- ☐ Stroke ________________
- ☐ Transplants_____________
- ☐ Tuberculosis Active ____
- ☐ Thyroid; Parathyroid disease
- ☐ Scleroderma
- ☐ Contact Lenses
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Psychiatric treatment
- ☐ Female: Taking Birth Control
- ☐ Female: Pregnant/Nursing
- ☐ Implant Birth control
- ☐ Male: Prostate disorders
- ☐ Shortness of breath
- ☐ Sickle Cell Disease
- ☐ Alcohol _______________
- ☐ Medical Marijuana ________
- ☐ Recreational Drug Use _____
- ☐ Cold Sores
- ☐ Epilepsy/Seizures _________
- ☐ any Lumps/swelling in mouth
- ☐ Glaucoma
- ☐ Addison's disease
- ☐ Eczema
- ☐ Anything other not listed: ____

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

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PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Print Name	Patient Signature	Date

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment? ____________________	☐	☐
How fearful, on scale of 1 (least) to 10 (Most)____________________		
Do you gag easily? ____________________	☐	☐
Do you wear dentures or partials? ____________________	☐	☐
Have you ever had braces or your bite adjusted? ____________________	☐	☐
Does food catch between your teeth? ____________________	☐	☐
Do you avoid brushing your mouth because of pain? ____________________	☐	☐
Do you gums bleed easily? ____________________	☐	☐
Do your gums bleed when you floss? ____________________	☐	☐
Do have family history with Periodontal (Gum) Disease in your family? ________	☐	☐
Are your teeth sensitive?_____ Hot/cold/sugars/pressure ________________	☐	☐
Are you satisfied with the appearance of your teeth? ____________________	☐	☐
How often do you brush? ____________________		
How often do you floss? ____________________		
Do you clench or grind you teeth? ____________________	☐	☐
Does your jaw ever feel sore? ____________________	☐	☐
Does you jaw ever get stuck so that you can't open freely? ________________	☐	☐
Does it hurt when you chew or open wide to take a bite or yawn? __________	☐	☐
Do you ever have headaches when you wake up? ____________________	☐	☐
Do you have Temporomandibular Jaw disorder (TMJ)? ____________________	☐	☐
Have you ever worn a Bite appliance? ____________________	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat or temples? _________	☐	☐
Have you ever had trauma to the jaw? ____________________	☐	☐
Do you bite your nails, chew gum, ice, and hard candy? ____________________	☐	☐
Are your teeth developing spaces or becoming loose? ____________________	☐	☐
Are you happy with the appearance of your teeth? ____________________	☐	☐

If you could change anything about your teeth what would you change? ________________

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Anything other you would like us to know? ____

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Our Policy Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-pf-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an ESTIMATE. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a pertain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

Dental insurance companies normally do not require a "predetermination" or "prior authorization". If the insurance company does require, we will be happy to submit a treatment plan to them.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance

I have read and understand the above.

Patient Signature________________________ Date________

Heritage Comfort Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

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