

Patient Information Form

Patient Name: _____
Last First MI

Preferred Name: _____

Male Female Birth Date: _____

Social Security #: _____ - _____ - _____

Address: _____
street apt#

city state zip

Phone: (_____) - _____ (home)

Phone: (_____) - _____ (work) ext: _____

E-mail: _____

Phone: (_____) - _____ (cell) _____

Employer Name: _____ Occupation: _____

Single Married Other Spouse's Name: _____

Whom may we thank for your referral? _____

Reason for your visit today. _____

Emergency contact/Relationship to patient: _____ Phone Number: _____

Medical information

Physician's Name: _____ Physician's Phone Number _____

Date of last physical: _____

Have you ever had any of the following (please check boxes that apply):

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> NONE
<input type="checkbox"/> ACID REFLUX
<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> ALLERGIES (non-seasonal)
<input type="checkbox"/> ALZHEIMERS/DEMENTIA
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> ANGINA
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> ARTIFICIAL HEART VALVE
<input type="checkbox"/> ARTIFICIAL JOINT
<input type="checkbox"/> ASTHMA
<input type="checkbox"/> BLEEDING PROBLEMS
<input type="checkbox"/> CANCER
<input type="checkbox"/> CHEMO/RAD THERAPY
<input type="checkbox"/> DIABETES | <input type="checkbox"/> DIZZINESS
<input type="checkbox"/> DAILY ASPIRIN
<input type="checkbox"/> DRUG/ALCOHOL ADDICTION
<input type="checkbox"/> EMPHYSEMA
<input type="checkbox"/> EPILEPSY, SEIZURES
<input type="checkbox"/> FAINTING
<input type="checkbox"/> HEADACHES
<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> HEART SURGERY
<input type="checkbox"/> HEART MURMUR
<input type="checkbox"/> HEART CONDITIONS
<input type="checkbox"/> HEPATITIS (A,B,C,D)
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> MITRAL VALVE PROLAPSE
<input type="checkbox"/> NO EPINPHRINE
<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> PACEMAKER
<input type="checkbox"/> PSYCHIATRIC CARE
<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> TOBACCO USER
<input type="checkbox"/> STROKE
<input type="checkbox"/> SWOLLEN NECK GLANDS
<input type="checkbox"/> THYROID PROBLEMS
<input type="checkbox"/> TUBERCULOSIS, (TB) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please describe any checked boxes: _____

Has your physician recommended that you take antibiotics prior to dental treatment? yes no

Are you allergic to any medications? yes no

If so, please list all medications: _____

Are you taking any medications at this time (including daily aspirin)? yes no

If so, please **clearly** list all medications: _____

Are you currently pregnant? yes no Breastfeeding yes no

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication

Signature: X _____

Date: _____

Dental Information

Why did you leave your previous dentist? _____

When was your last cleaning? _____ Oral Cancer Screening _____ x-rays _____

Name of previous dentist _____ City _____ State _____

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

Have you ever had any problems with past dental treatment? _____

Does dental treatment make you nervous? yes moderately slightly no

We do believe that anxiety may stop patients from having their dental work done, so please ask about relaxation options for your visit.

Have you ever had gum treatments or seen a periodontist? yes no

Have you ever had any allergic reactions with dental treatment? Any complaints with treatment received? yes no

If yes, please explain: _____

Do you have any of the following?

MOUTH

Bleeding, sore, swollen gums yes no

Unpleasant taste/breath odor yes no

Orthodontic treatment yes no

Clicking/popping jaw or pain yes no

TEETH

Loose, Broken, Shifting teeth yes no

Sensitive to cold, hot, sweet yes no

Clenching/grinding yes no

Tooth pain/discomfort when chewing yes no

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

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Smile Evaluation

Do you have any spaces, missing teeth or crowding that you would like to change? yes no

Are you interested in changing crowns with metal and/or mercury fillings to metal free? yes no

Do you have any teeth or crowns that you are concerned about? yes no

Are you happy with the color of your teeth? yes no

Are you interested in whitening your teeth or have you done so in the past? When? _____ yes no

Are you interested in finding out what your smile could look like with cosmetic imaging? yes no

If you could change anything about your smile what would you change? _____

Sleep Evaluation

Do you snore or have been told that you snore? yes no

Do you often feel tired, fatigued, or sleepy during the daytime? yes no

Has anyone observed you stop breathing or gasp for air during your sleep? yes no

Do you have or are you being treated for high blood pressure? yes no

Have you ever been diagnosed with Sleep Apnea? yes no

Are you currently using CPAP or unable to use CPAP? (or any other apnea/snoring device) yes no

Insurance Information

Initial: _____ - We accept assignment of benefits as an OUT OF NETWORK dentist. All benefits are based on estimates from your insurance company and are not exact amounts. By law, your insurance does not release exact amounts to dental practices.

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insured's Birth Date: _____ Social Security #: _____ - _____ - _____

Group #: _____

Insured's employer name: _____

Dental insurance company name: _____

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Signature of patient, parent or guardian

Date

Consent for Services

1. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
2. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. **The office staff will estimate insurance coverage to the best of their ability, but the patient agrees that this is an estimate only, not a guarantee of coverage.**
3. *All patient accounts 60 days past due are considered delinquent, and those 90 days past due are subject to collections.
4. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
5. I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient

Jerry Dunn,
DDS



**A \$50.00 DOLLAR FEE WILL BE
CHARGED FOR ALL
CANCELLED APPOINTMENTS,
WITHOUT 24-HOUR NOTICE**

Advanced Dental Care

Jerry Dunn, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kelly Bullock Telephone: 972-506-9688 Fax: 972-506-9321

Address: 1075 Kinwest Pkwy, Suite 100, Irving Texas 75063

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 treating you if you revoke this Consent.

SIGNATURE

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

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.

In addition to the above, I give permission to share my health information with the following person/persons.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.