Welcome

Please complete the following confidential information:

Date: _____

Patient Name: _____
Last First Initial

How do you wish to be addressed: _____

Date of Birth: _____

Please circle one: Male Female

Parent/Guardian Name (if patient is a child):

_____

Please circle one:

Single Married Separated

Divorced Widowed Minor

Street Address: _____

City: _____ State: _____ Zip: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Work: _____

Email: _____

Which is the best way to contact you? _____

Responsible Party:

Name: _____

Cell: _____ Work: _____

Street Address:_____

City: _____ State: _____ Zip: _____

Driver's License Number: _____

In case of an emergency (Please list at least one non-relative):

Emergency Contact: _____

Cell: _____ Relationship: _____

Emergency Contact: _____

Cell: _____ Relationship: _____

Whom may we thank for this referral?

_____

DENTAL INSURANCE COVERAGE

Policy Holder: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company Name: _____

Insurance Phone Number: _____

Group Number: _____

Member ID Number: _____

Insurance Address: _____

_____

INFORMED CONSENT

I consent to the diagnostic procedures and treatment by the dentist or designated staff necessary for proper dental care.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I attest that I have received a copy of this office's Notice of Privacy Practices.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. (Ex: non-custodial parent, etc.)

I attest to the accuracy of the information on this page.

_____

Patient / Guardian Signature Date

PATIENTS WITH INSURANCE

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid by my insurance carrier.

Patient/Guardian Signature Date

APPENDIX G – AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND HIPAA COMMUNICATION CONSENT FORM

Patient Name:	**Date of Birth:**

This consent form allows Tanglewood Dental Associates to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, or health care operations.

Tanglewood Dental Associates has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Tanglewood Dental Associates.

_____ (Initial) I hereby authorize that Tanglewood Dental Associates may leave messages on my voicemail to confirm my appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ (Initial) I hereby authorize that Tanglewood Dental Associates may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office meet with my dentist and staff.

_____ (Initial) I hereby authorize that Tanglewood Dental Associates may disclose my personal health information to the person who I have listed as my emergency contact.

_____ (Initial) I hereby authorize that Tanglewood Dental Associates may disclose my personal health information to the following person(s):

NAME:	**TELEPHONE NUMBER:**	**RELATIONSHIP TO PATIENT:**

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Tanglewood Dental Associates services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Tanglewood Dental Associates may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used of disclosed to carry out treatment, payment and health care operations and must be provided by me in writing. I understand that while Tanglewood Dental Associates is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature, I affirm the above information.

Signature of Patient: _____ Date: _____

Authorized Representative: _____ Date: _____

MEDICAL HISTORY

Date: _____

Patient Name: **Date of Birth:**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If yes:	_____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes:	_____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes:	_____
Are you taking any medications, pills, drugs?	O Yes	O No	If yes, please fill out the following sheet with **all** current medications.	
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If yes:	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	If yes:	_____
Are you on a special diet?	O Yes	O No		
Do you use tobacco?	O Yes	O No		

Women: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking Oral Contraceptives

Are you allergic to any of the following?

□ Aspirin	□ Penicillin	□ Codeine	□ Acrylic
□ Metal	□ Latex	□ Sulfa Drugs	□ Local Anesthetics

Other?	O Yes	O No	If yes:	_____
Do you use controlled substances?	O Yes	O No	If yes:	_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes	O No	Cortisone Medicine	O Yes	O No	Hemophilia	O Yes	O No	Radiation Treatments	O Yes	O No
Alzheimer's Disease	O Yes	O No	Diabetes	O Yes	O No	Hepatitis A	O Yes	O No	Recent Weight Loss	O Yes	O No
Anaphylaxis	O Yes	O No	Drug Addiction	O Yes	O No	Hepatitis B or C	O Yes	O No	Renal Dialysis	O Yes	O No
Anemia	O Yes	O No	Easily Winded	O Yes	O No	Herpes	O Yes	O No	Rheumatic Fever	O Yes	O No
Angina	O Yes	O No	Emphysema	O Yes	O No	High Blood Pressure	O Yes	O No	Rheumatism	O Yes	O No
Arthritis/Gout	O Yes	O No	Epilepsy/Seizures	O Yes	O No	High Cholesterol	O Yes	O No	Scarlet Fever	O Yes	O No
Artificial Heart Valve	O Yes	O No	Excessive Bleeding	O Yes	O No	Hives or Rash	O Yes	O No	Shingles	O Yes	O No
Artificial Joint	O Yes	O No	Excessive Thirst	O Yes	O No	Hypoglycemia	O Yes	O No	Sickle Cell Disease	O Yes	O No
Asthma	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No	Irregular Heartbeat	O Yes	O No	Sinus Trouble	O Yes	O No
Blood Disease	O Yes	O No	Frequent Cough	O Yes	O No	Kidney Problems	O Yes	O No	Spina Bifida	O Yes	O No
Blood Transfusion	O Yes	O No	Frequent Diarrhea	O Yes	O No	Leukemia	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Breathing Problems	O Yes	O No	Frequent Headaches	O Yes	O No	Liver Disease	O Yes	O No	Stroke	O Yes	O No
Bruise Easily	O Yes	O No	Genital Herpes	O Yes	O No	Low Blood Pressure	O Yes	O No	Swelling of limbs	O Yes	O No
Cancer	O Yes	O No	Glaucoma	O Yes	O No	Lung Disease	O Yes	O No	Thyroid Disease	O Yes	O No
Chemotherapy	O Yes	O No	Hay Fever	O Yes	O No	Mitral Valve Prolapse	O Yes	O No	Tonsillitis	O Yes	O No
Chest Pains	O Yes	O No	Heart Attack/Failure	O Yes	O No	Osteoporosis	O Yes	O No	Tuberculosis	O Yes	O No
Cold Sores/Fever Blisters	O Yes	O No	Heart Murmur	O Yes	O No	Pain in jaw Joints	O Yes	O No	Tumors or Growths	O Yes	O No
Congenital Heart Disorder	O Yes	O No	Heart Pacemaker	O Yes	O No	Parathyroid Disease	O Yes	O No	Ulcers	O Yes	O No
Convulsions	O Yes	O No	Heart Trouble/Disease	O Yes	O No	Psychiatric Care	O Yes	O No	Venereal Disease	O Yes	O No
									Yellow Jaundice	O Yes	O No

Have you ever had any serious illness not listed? O Yes O No If yes: _____

Comments:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature, Parent or Guardian:

X_____ Date: _____

Doctor Signature:

X_____ Date: _____

NAME:	DATE:

List of Medications: Including over the counter	Strength	A.M.	Noon	P.M.	Reason for Taking:	Office use only: Medication current? (Date/Initial)

DENTAL HISTORY

Patient Name:	**Medical Alert:**

Welcome! *So that we may provide you with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit: ___/___/___ Last Dental Cleaning: ___/___/___ Last Full Mouth X-rays: ___/___/___

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Office Phone: _____-_____-_____

Address: _____ City/State: _____ Zip Code: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, Sonicare, toothpick, etc.) _____

Have you ever or do you now wear dentures or partials? Yes _____ No _____ If yes, for how long? _____

Do you have any bridges or crowns? Yes _____ No _____

If yes, where are they located and how long have you had them? _____

Do you have any dental problems now? Yes _____ No _____ If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
A bite plate or mouth guard?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		
Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Is so, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		

Is there anything else about having dental treatment that you would like us to know? Yes _____ No _____
If yes, please describe: _____
_____