Patient Information

Patient Name_____ ____ Date_____
Last First MI

(Preferred Name)_____

- Male □Married □Single □Child □Other
- Female

Birth Date_____ Social Security#_____

Address_____
Street or PO Box City State Zip Code

Phone(Home)_____ (Cell)_____

Employer_____ (Work)_____

Email address_____

Primary Dental Insurance Company _____

Secondary Dental Insurance Company _____

Spouse or Responsible Party Information

Name_____ _____ □Married □Single □Child □Other
Last First MI

Birth Date_____ Social Security #_____ _____ □Male □Female

Address_____
Street or PO Box City State Zip Code

Phone (Home/Cell)_____ (Work)_____

Employer_____Address_____

Emergency Contact Information

Name_____ Phone (Home/Cell)_____(Work)_____

Name_____ _____Phone (Home/Cell)_____(Work)_____

Referral Information

Whom may we thank for referring you to our practice? □ Another Patient(Name)_____

□ Yellow Pages □ Newspaper □ School/Work, (Name)_____ □ Other _____

Dental Health Partners

Dental History

Have you ever had any complications following dental treatment? ( ) Yes ( ) No
If yes, please explain_____ (prolonged bleeding, numbness, etc)

Do your gums bleed while brushing? ( ) Yes ( ) No

Do you feel pain in any of your teeth? ( ) Yes ( ) No

Do you feel any clicking or pain in your jaw or difficulty opening or closing? ( ) Yes ( ) No

Date of last dental visit? _____ Reason for today's visit_____

Are you interested in straightening your teeth ( ) Yes ( ) No

If you could change anything about your teeth, what would it be? _____

Have you ever had botox?_____ If not are you interested?_____

Health Information

Check (x) if you have or have had any of the followings:

( ) AIDS (HIV)
( ) Anemia
( ) Arthritis
( ) Artificial Joint/Joint Replacement
( ) Asthma
( ) Blood Disease
( ) Blood Thinner
( ) Cancer
( ) Diabetes
( ) Dizziness
( ) Eating Disorders
( ) Epilepsy
( ) Excessive Bleeding
( ) Fainting
( ) Glaucoma
( ) Head Injuries
( ) Heart Disease
( ) Heart Murmur
( ) Hepatitis
( ) High Blood Pressure
( ) Kidney Disease
( ) Latex Allergy
( ) Liver Disease
( ) Mental Disorders
( ) Nervous Disorders
( ) Pacemaker
( ) Pregnancy (Current) due date _____
( ) Radiation Therapy
( ) Respiratory Problems
( ) Rheumatic Fever
( ) Sinus Problems/Hay Fever
( ) Stomach Problems
( ) Stroke
( ) Tuberculosis
( ) Tumors
( ) Ulcers
( ) Venereal Diseases
( ) Codeine Allergy
( ) Penicillin Allergy
( ) Sulfa Allergy
( ) Pre Med/Antibiotic needed
( ) Tobacco Use

Are you currently taking or have taken in the past any of the following Bisphosphonates: _____
( )Actonel ( )Fosamax ( )Boniva ( )Didronel ( )Aredia ( )Skelid ( )Reclast ( )Zometa ( )Fosamax Plus D

List ALL MEDICATION (including: aspirin, birth control): _____

_____

List ALL SUPPLEMENTS: _____

List ALL ALLERGIES: _____

Recent SURGERIES: _____

Physician Name: _____ Phone: _____

Now being treated for _____

To the best of my knowledge, all of the above information is true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fall.

Patient/Parent/Guardian Signature:_____ *Date*:_____

For office use only:
Blood Pressure:_____ Heart Rate:_____ sp02:_____

Consent for Services

I _____ request and consent to an exam and radiographs as deemed
(Print Name)
necessary for diagnosis. I also request and consent to needed treatment as it is explained to me. If any unforeseen condition should arise in the course of treatment, I further consent to any procedure deemed necessary for my well-being. 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.
I hereby authorize the treating dentists of Dental Health Partners to release to the insurance company any information including the diagnosis and records of any treatment rendered to me during the period of such dental care. I also authorize and request the insurance company to pay directly to the above clinic the amount due for dental treatment. I also authorize the release of my dental records to referring dental providers or other only as deemed necessary by the dentists at Dental Health Partners.

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

_____ _____
Signature of Patient, Parent, or Guardian **Todays Date**

Mobile Phone Consent

I _____ understand and accept each of the following:
(Print Name)

- **Costs**. Standard text message and minute usage rates from my mobile or internet service provider may apply.
- **Privacy and Security**. Receiving voice and text messages from Dental Health Partners may impact the privacy and security of protected health information (PHI). Voice and text messages are not encrypted. Encryption makes sure information stays safe. Information in voice or text message may not be secure.
- **Revocation**. This consent to receive voice or text messages on my mobile phone will be in effect until I have notified Dental Health Partners, in writing, that I no longer want to receive messages on my mobile phone. I will let Dental Health Partners know if I no longer want to receive messages on my mobile phone.
- **Number Change.** I will let Dental Health Partners know if my mobile number changes.

☐ **Yes**, Dental Health Partners may call my mobile phone number recorded at Dental Health Partners about my care, treatment, services, and accounts using prerecorded messages, automatic telephone dialing systems and/or text messages.
☐ **No**, I do not authorize Dental Health Partners to call my cell phone number about my services and accounts using prerecorded messages, automatic telephone dialing systems and/or text messages.

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

_____ _____
Signature of Patient, Parent, or Guardian **Todays Date**

Dental Health Partners