Patient Information

PioneerValley DENTAL
Family Values, Personal Touch, Professional Service

Patient Name _____ (Last) _____ (First) _____ (M.I.)

Preferred Name _____ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐

Date of Birth _____ Age _____ Social Security # _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer Name _____ I would like to receive appointment reminders via text messages? ☐

Emergency Contact _____ Phone Number _____

Guarantor Name _____ (Last) _____ (First) _____ (M.I.) Male ☐ Female ☐ Married ☐ Single ☐

Date of Birth _____ Age _____ Social Security # _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer Name _____ I would like to receive appointment reminders via text messages? ☐

How did you hear about our office? Friend/Relative - Name _____

Internet ☐ Yellow Pages ☐ Mailer ☐ Location ☐ Insurance ☐ Other ☐

Rate your smile from 1-10 1 2 3 4 5 6 7 8 9 10

What dental services are you interested in to make your smile a 10?

- ☐ Smile Whitening
- ☐ Replacing Silver Fillings
- ☐ Replacing Old Crowns that Don't Match
- ☐ Replacing Missing Teeth with Implants
- ☐ Repair Chipped Teeth
- ☐ Closing Spaces between My Teeth
- ☐ Braces or Invisalign
- ☐ Smile Makeover

Any other dental concerns that you may have? _____

_____

Signature of Patient or Guardian _____ Date _____

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CONSENT TO PROCEED

I authorize Dr._____ and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(Patient, Legal Guardian or Authorized Agent of Patient)

Witness: _____ Date: _____

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Dental Information

Do your gums bleed when you brush or floss? ..... Yes No
Do you have a problem with food wedging between your teeth? ..... Yes No
Are your teeth sensitive to cold, hot, sweets or pressure? ..... Yes No
Do you feel your mouth is unusally dry? ..... Yes No
Do you have frequent bad breath or an unpleasant taste in your mouth? ..... Yes No
Do you feel like you have had good dental care in the past? ..... Yes No
If not, why? _____
When was your last dental appointment? _____
What was that appointment for? _____
Do you feel nervous about having dental treatment? ..... Yes No
In our office we offer nitrous oxide (laughing gas) analgesia to help relieve tension, fear, and anxiety.
Would you be interested in using nitrous oxide during your treatment? ..... Yes No
Have you had orthodontic treatment in the past? ..... Yes No
Do you currently wear a retainer? ..... Yes No
Do you have any popping, clicking or discomfort in the jaw joints? ..... Yes No
Do you participate in any sports or active recreational activities? ..... Yes No
Are you having any dental pain or discomfort at this time? ..... Yes No
If yes, what area of the mouth? (ie. upper left) _____ How long? _____

Medical Information

Are you in good health? ..... Yes No
Have you been under the care of a physician in the past two years? ..... Yes No
If yes, what is your physician's name? _____ Telephone: _____
Have you been hospitalized in the past two years? ..... Yes No
Are you currently taking any medications? ..... Yes No
If yes, for what? _____
What medications are you taking? _____
Are you allergic or made sick by any medications? ..... Yes No
If yes, to what? _____
Are you allergic to latex or metals? .... ☐ Latex ☐ Metals

Please mark (X) to indicate if you have had any of the following diseases or medical conditions.

☐ Orthopedic Joint Replacement
☐ Osteoporosis
If yes, have you ever taken Fosamax or Actonel
☐ Rheumatic Fever
☐ Heart Murmur
☐ Artificial Heart Valve
☐ Angina
☐ Heart Failure, Disease or Attack
☐ Pacemaker
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Diabetes I or II
☐ Kidney Trouble
☐ Ulcers
☐ Emphysema
☐ Tuberculosis
☐ Asthma
☐ Hay Fever, Allergies, or Hives
☐ Sinus Trouble
☐ Arthritis
☐ Cancer/Chemotherapy/Radiation
☐ Steroid Medications
☐ AIDS or HIV Infection
☐ Sexually Transmitted Diseases
☐ Hepatitis A,B or C or other Liver Diseases
☐ Anemia, Blood Transfusion, Hemophilia or Bruise Easily
☐ Drug Addiction
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Stroke
☐ Psychiatric Treatment
Female:
☐ Pregnant
☐ Taking Birth Control Pills (Antibiotics may render oral contraceptives ineffective)
☐ Nursing
☐ Other: _____

I certify that I have read and understand the above and that the information given is an accurate and truthful health history.

Signature of Parent/Legal Guardian: _____ Date: _____

Agreement of Financial Responsibility

The responsible party agrees to pay the doctor at the time of treatment or service is received or by previous arrangements. In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, such as when insurance payment is pending, please be advised of the following policies which apply in this office. The responsible party agrees:

- that if payment is extended beyond 30 days from the date of treatment, a monthly service charge of 1.5% (18% per year) on the unpaid balance will be assessed. Interest not paid when due shall be added to and become part of the principal.
- that should this balance become delinquent and be placed with an agency for collection, I agree to pay the remaining balance plus the sum of 40% and any other reasonable attorney fees and court costs, in addition to an in-office collection fee of $75.00.
- that even though I have some type of insurance coverage, I am responsible for the entire payment of services

Permission is given to obtain a credit report if credit is applied for.

I hereby authorize any insurance company, prepayment organization, employer, hospital or health care provider, to release all information with respect to myself or any of my dependent children which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

I hereby authorize paymenl of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

1) Dental insurance is not meant to be a pay-all, it's only meant to be an aid.

2) Many plans tell you that you'll be covered "up to 80-100%." In spite of what you are told, we have found most plans cover only 40 - 60% of an average fee. The amount your plan pays is determined by how much your employer paid for the plan. The less your employer paid for the insurance, the lower the insurance benefit you will receive.

3) It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary" rather than admitting, "our benefits are low." Please request a copy of your insurance company's "UCR" fee schedule to establish your benefit level.

4) Many routine dental services are not covered by dental insurance at all.

If you have any questions regarding your insurance, you should contact your company regarding the details of the plan it is conducting in your behalf. We are happy to help you submit your claims, and we will try to get the maximum benefit for you that your plan provides.

Signature: _____ Date: _____

(Patient, Legal Guardian or Authorized Agent of Patient)

Witness: _____ Date: _____