

## Adult Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Phone Number (Land Lines Only): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

### Emergency Contact Information

Full Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### How did you hear about us?

Family / Friend / Co-worker

Who can we thank for your referral? \_\_\_\_\_

Online (Google, etc.)

Insurance

Other

**To the best of my knowledge, all the information I have provided is true**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Parent/ Guardian)

\_\_\_\_\_  
Relationship if not Patient

# Dental History Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason you are seeking dental treatment? \_\_\_\_\_

When was your last dental visit and exam? \_\_\_\_\_

How routinely did you see your previous dentist?  3 month  4 month  6 month  12 month  not routinely

How often do you brush and floss? (Please circle)

Brush: 1 / 2 / 3+ - PER: Day / Week / Month / Never - Manual toothbrush / Electric toothbrush

Floss: 1 / 2 / 3+ - PER: Day / Week / Month / Never

- Yes  No Do you use any other oral hygiene tools? (check all that apply)  
 Water flosser  Interproximal brushes  Mouth rinse  Other \_\_\_\_\_
- Yes  No Do you use fluoride in any form (check all that apply)  
 Toothpaste  Drinking water  Mouth rinse  Other \_\_\_\_\_
- Yes  No Do you wear any oral appliances (check all that apply)  
 Dentures  Partials  Bite appliance (night guard)  Orthodontic Retainers  Other
- Yes  No Have you ever had orthodontic treatment (Braces)?
- Yes  No Do you still have your wisdom teeth?
- Yes  No Have you ever had periodontal (gum tissue) treatment, such as deep cleaning, root planning, or periodontal surgery?
- Yes  No Have you ever had trouble getting numb or had any reactions to local anesthetics?

How do you feel about dental treatment?  Excited  Relaxed  Anxious  Extreme Phobia

Has fear ever prevented you from receiving dental treatment?  Yes  No

What concerns do you currently have with your oral health or smile? (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Tooth sensitivity to hot/cold/sweets | <input type="checkbox"/> Clenching or grinding of teeth      | <input type="checkbox"/> Unhappy with appearance of teeth |
| <input type="checkbox"/> Sores or lumps in your mouth         | <input type="checkbox"/> Pain (jaw joint, ear, side of face) | <input type="checkbox"/> Discolored teeth                 |
| <input type="checkbox"/> Bleeding gums                        | <input type="checkbox"/> Clicking/popping in jaw             | <input type="checkbox"/> Crowding/Crooked teeth           |
| <input type="checkbox"/> Missing teeth                        | <input type="checkbox"/> Difficulty chewing                  | <input type="checkbox"/> Spaces in between teeth          |
| <input type="checkbox"/> Loose teeth                          | <input type="checkbox"/> Difficulty opening or closing mouth | <input type="checkbox"/> Too much gum tissue when I smile |
| <input type="checkbox"/> Food gets caught in between teeth    | <input type="checkbox"/> Frequent headaches                  | <input type="checkbox"/> Dry mouth                        |
| <input type="checkbox"/> Bad breath                           |  |   |

Are you interested in changing the appearance of your teeth?  Yes  No If yes, please explain below:

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications 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?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please list: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

**Women: Are you:**

Pregnant/Trying to get pregnant?  Yes  No      Taking oral contraceptives?  Yes  No      Nursing?  Yes  No

**Are you allergic to any of the following?**

- Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex     Sulfa Drugs
- Other      If other, please explain: \_\_\_\_\_

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

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive	<input type="radio"/>	<input type="radio"/>	Cortisone Medicine	<input type="radio"/>	<input type="radio"/>	Hemophilia	<input type="radio"/>	<input type="radio"/>	Radiation Treatment	<input type="radio"/>	<input type="radio"/>
Alzheimer's Disease	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Hepatitis A	<input type="radio"/>	<input type="radio"/>	Recent Weight Loss	<input type="radio"/>	<input type="radio"/>
Anaphylaxis	<input type="radio"/>	<input type="radio"/>	Drug Addiction	<input type="radio"/>	<input type="radio"/>	Hepatitis B or C	<input type="radio"/>	<input type="radio"/>	Renal Dialysis	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Easily Winded	<input type="radio"/>	<input type="radio"/>	Herpes	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Angina	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Rheumatism	<input type="radio"/>	<input type="radio"/>
Arthritis/Gout	<input type="radio"/>	<input type="radio"/>	Epilepsy or Seizures	<input type="radio"/>	<input type="radio"/>	High Cholesterol	<input type="radio"/>	<input type="radio"/>	Scarlet Fever	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>	Excessive Bleeding	<input type="radio"/>	<input type="radio"/>	Hives or Rash	<input type="radio"/>	<input type="radio"/>	Shingles	<input type="radio"/>	<input type="radio"/>
Artificial joint	<input type="radio"/>	<input type="radio"/>	Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Hypoglycemia	<input type="radio"/>	<input type="radio"/>	Sickle Cell Disease	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Fainting Spells/Dizziness	<input type="radio"/>	<input type="radio"/>	Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>	Sinus Trouble	<input type="radio"/>	<input type="radio"/>
Blood Disease	<input type="radio"/>	<input type="radio"/>	Frequent Cough	<input type="radio"/>	<input type="radio"/>	Kidney Problems	<input type="radio"/>	<input type="radio"/>	Spina Bifida	<input type="radio"/>	<input type="radio"/>
Blood Transfusion	<input type="radio"/>	<input type="radio"/>	Frequent Diarrhea	<input type="radio"/>	<input type="radio"/>	Leukemia	<input type="radio"/>	<input type="radio"/>	Stomach/Intestinal Disease	<input type="radio"/>	<input type="radio"/>
Breathing Problem	<input type="radio"/>	<input type="radio"/>	Frequent Headaches	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Bruise Easily	<input type="radio"/>	<input type="radio"/>	Genital Herpes	<input type="radio"/>	<input type="radio"/>	Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	Swelling of Limbs	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Lung Disease	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>
Chemotherapy	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>	Mitral Valve prolapse	<input type="radio"/>	<input type="radio"/>	Tonsillitis	<input type="radio"/>	<input type="radio"/>
Chest pains	<input type="radio"/>	<input type="radio"/>	Heart attack/Failure	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Cold Sores/Fever Blisters	<input type="radio"/>	<input type="radio"/>	Heart Murmur	<input type="radio"/>	<input type="radio"/>	Pain in Jaw Joints	<input type="radio"/>	<input type="radio"/>	Tumors or Growths	<input type="radio"/>	<input type="radio"/>
Congenital Heart Disorder	<input type="radio"/>	<input type="radio"/>	Heart Pacemaker	<input type="radio"/>	<input type="radio"/>	Parathyroid Disease	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>	Heart Trouble/Disease	<input type="radio"/>	<input type="radio"/>	Psychiatric Care	<input type="radio"/>	<input type="radio"/>	Venereal Disease	<input type="radio"/>	<input type="radio"/>
									Yellow Jaundice	<input type="radio"/>	<input type="radio"/>

Have you ever had any serious illness not listed above?  Yes  No If yes, please list: \_\_\_\_\_

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Parent/ Guardian)

\_\_\_\_\_  
Relationship if not Patient

# HIPAA Consent Form

## Consent for the use and disclosure of health information

### 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. Copies of our Notice of Privacy Practice are available at the front desk and on our website.

**Persons Involved in Care:** I give my consent for Complete Family Dentistry to discuss my dental treatment (past, present and future) and dental finances related to that treatment with the following person or persons:

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Relationship

**Methods of Communication Consent:** I authorize Complete Family Dentistry to contact me regarding my (or my child's) dental care via all methods I have provided (text, email, phone).

**Wisconsin Consent:** I consent to the diagnostic procedures and treatment by the dentist, hygienist, and/or assistant necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) records to carry out treatment, consult with other practitioners, obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care 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 services not paid, by my dental care payor.

**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 healthcare operations. My consent will be effective until I revoke it in writing.**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Parent/ Guardian)

\_\_\_\_\_  
Relationship if not Patient

## Financial Policy

Thank you for choosing Complete Family Dentistry for your dental needs. This agreement is to inform you of your financial obligation to our practice. We are committed to providing you and your family with comprehensive dental care using current techniques and high quality materials. We will always recommend treatment based upon your dental needs, not based on insurance coverage. All charges you incur for treatment that is provided are your responsibility regardless of your insurance coverage.

### **Full payment is due on the day of treatment**

If we accept assignment of insurance, you are responsible for your estimated portion at the time of service. Any amount not covered by the insurance company will be billed to you. We request that patients without dental insurance be prepared to pay at the time of service.

### **Day of Service Payment Discounts**

For those patients without dental insurance we offer discounts when payment is paid in full, at the time of service. We offer: 7% Day of Service Courtesy Adjustment and 10% for those 60 and older. Only one discount can be applied to your bill.

### **Payment Options**

Several payment options are available to assist you in fulfilling your financial obligations whether you have dental insurance or not. We accept: Cash, Check, Credit (Visa, MasterCard, Discover), Debit, HSA, FSA and Care Credit. A 3% Credit Card convenience fee will be applied to all credit card transactions to cover processing costs. There is no processing cost for debit card, HSA, or FSA transactions. Care Credit offers third party deferred interest financing options upon approval. For more information or to apply, visit [www.carecredit.com](http://www.carecredit.com)

### **Insurance**

Our office will file insurance claims on your behalf without a charge. It is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Our office does not guarantee payment or coverage by your insurance company. Dental insurance usually pays only a portion of your charges and we urge you to be fully aware of the provisions of your dental plan's policy. You are responsible for your estimated portion at the time of service. Please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. Any remaining balance after your insurance has settled a claim and/or paid is your responsibility.

### **Broken Appointments**

Since our time with our patients is very important to us and lost time is irretrievable, we reserve the right to charge for broken appointments when we have not been notified at least 24 hours in advance. Our charge for broken appointments is \$50.00. Our desire is never to find it necessary to make this charge. Please keep your appointment, we are waiting for you.

### **Past Due Balances**

Please note if your balance is not paid in full, interest rates may apply. Our policy is to charge 1.5% monthly interest that will be applied to all accounts 30 days past due. Any account 90 days past due may be turned over to collections. Fees incurred to collect payment will be billed to and payable by the responsible party on the account.

### **Returned Checks**

We will charge \$50.00 for returned checks.

**By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am financially responsible for all dental services rendered to me and my dependents (if applicable).**

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Print Patient Name

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Date

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Signature of Patient (or Parent/ Guardian)

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Relationship if not Patient