GLEN VALLEY
DENTISTRY

PATIENT INFORMATION

Name: _____ Birth date_____ / _____ / _____

Address: _____ City _____ Zip Code _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Email: _____ @ _____ . _____

Driver's License #_____ SSN: _____ - ____ - _____

I would like to confirm my appointments with ☐ Text ☐ Email ☐ Automated Call

How would you like to be addressed when summoned from the reception area?

☐ First Name ☐ Nickname: _____

Whom may we thank for referring you? _____

Dental Insurance Information

Name of Insured_____ Birth Date ___ / ___ /_____ Employer _____

Relationship to Patient_____ Insurance Comp_____

Insurance Phone # ( ) _____ - _____ Insurance ID# or SSN _____ Group #_____

Secondary Dental Insurance Information (if applicable)

Name of Insured_____ Birth Date ___ / ___ /_____ Employer _____

Relationship to Patient_____ Insurance Comp_____

Insurance Phone # ( ) _____ - _____ Insurance ID# or SSN_____ Group #_____

Who should we contact in case of emergency?

Name: _____

Relationship to Patient_____ Phone # ( ) _____ - _____

MEDICAL INFORMATION

Patient Name _____

Name of Physician/ and their specialty _____

Most recent physical examination_____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	Y	N
1.Hospitalization for illness or injury _____		
2. An allergic or bad reaction to any of the following: ☐ Aspirin, ibuprofen, acetaminophen, codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Local anesthetic ☐ Fluoride ☐ Chlorhexidine (CHX) ☐ Metal (nickel, gold, silver, _____) ☐ Latex ☐ Nuts _____ ☐ Fruits _____ ☐ Other_____		
3. Heart problems, or cardiac stent within the last six months		
4. History of infective endocarditis		
5. Artificial heart valve, repaired heart defect (PFO)		
6. Pacemaker or implantable defibrillator_____		
7. Orthopedic implant (joint replacement)		
8. Rheumatic or scarlet fever _____		
9. High or low blood pressure _____		
10. Stroke (taking blood thinners)		
11. Anemia or other blood disorder _____		
12. Prolonged bleeding due to slight cut		
13. Pneumonia, emphysema, shortness of breath, sarcoidosis _____		
14. Chronic ear infection, tuberculosis, measles, chicken pox		
15. Asthma		
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)		
17. Kidney disease		
18. Liver disease		
19. Thyroid, parathyroid disease, or calcium deficiency		
20. Hormone deficiency		
21. High cholesterol or taking statin drugs		
22. Diabetes (HbA1c = _____)		

DO YOU HAVE OR HAVE YOU EVER HAD:	Y	N
23. Stomach or duodenal ulcer		
24. Digestive or eating disorder (i.e. celiac disease, gastric reflux, bulimia, anorexia)		
25. Osteoporosis/osteopenia (i.e. taking bisphosphonates)		
26. Arthritis		
27. Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)		
28. Glaucoma		
29. Contact Lenses		
30. Head or neck injuries		
31. Epilepsy, convulsions (seizures)		
32. Neurologic, disorders (ADD/ADHD, prion disease)		
33. Viral infections and cold sores		
34. Any lumps or swelling in the mouth		
35. Hives, skin rash, hay fever _____		
36. STI/STD/HPV _____		
37. Hepatitis (type ____)		
38. HIV/AIDS _____		
39. Tumor, abnormal growth		
40. Radiation therapy		
41. Chemotherapy, immunosuppressive medication		
42. Psychiatric treatment		
43. Antidepressant medication		
44. Alcohol/recreational drug use		
ARE YOU:	**Y**	**N**
45. Presently being treated for any other illness		
46. Aware of a change in your healthy in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)		
47. Taking medication for weight management		
48. Taking dietary supplements		
49. Often exhausted or fatigued		
50. Experiencing frequent headaches		
51. A smoker, smoked previously or use smokeless tobacco		
52. Often unhappy or depressed		
53. Taking birth control pills		
54. Currently pregnant		
55. Diagnosed with a prostate disorder		

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date_____

Patient Name: Date:

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Previous Dentist _____ _____How long have you been a patient? _____
Date of most recent dental exam _____ Date of most recent xrays_____
Date of most recent treatment (other than cleaning) _____

I see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern?

PERSONAL HISTORY	Yes	No
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) 10 (most)_____		
2. Have you had an unfavorable dental experience?		
3. Have you ever had complications from past dental treatment?		
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?		
6. Have you had any teeth removed or missing teeth that never developed?		
7. Do your gums bleed or are they painful when brushing or flossing?		
GUM AND BONE	Yes	No
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
9. Have you ever noticed an unpleasant taste or odor in your mouth?		
10. Is there anyone with a history of periodontal disease in your family?		
11. Have you ever experienced gum recession?		
12. Have you had any teeth become loose on their own (without injury) or do you have difficulty eating apples?		
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		
TOOTH STRUCTURE	Yes	No
14. Have you had any cavities within the past 3 years?		
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?		
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?		
18. Do you have grooves or notches on your teeth near the gum line?		
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
20. Do you frequently get food caught between your teeth?		
BITE AND JAW JOINT	Yes	No
21. Do you have problems with your jaw joint?		
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?		
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars or other hard, dry foods?		
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?		
25. Are your teeth becoming more crooked, crowded, or overlapped?		
26. Are your teeth developing spaces or becoming looser?		
27. Do you have more than one bite or do you squeeze or shift your jaw to make your teeth fit?		
28. Do you place your tongue between your teeth or close your teeth against your tongue?		
29. Do you chew ice, bite your nails, hold objects in your teeth or have any other oral habits?		
30. Do you clench your teeth in the daytime or make them sore?		
31. Do you have any problems with sleep or wake up with an awareness of your teeth?		
32. Do you wear or have ever worn a bite splint?		
SMILE CHARACTERISTICS	Yes	No
33. Is there anything about the appearance of your teeth that you would like to change?		
34. Have you ever whitened (bleached) your teeth?		
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?		
36. Have you been disappointed with the appearance of previous dental work?		

FINANCIAL AGREEMENT

RESPONSIBLE PARTY FOR ACCOUNT: PLEASE READ THE FOLLOWING & SIGN

Responsible Party for Account: _____

Names of patients on account, Please list yourself and any family members you are financial responsible for:

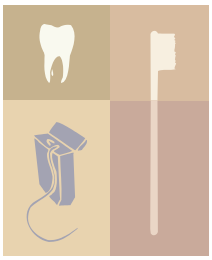
Billing Address: _____

City _____ State ____ Zip Code _____

Phone Number: ( ) _____ - _____

E-mail: _____ @ _____. _____

To our patients <u>with</u> insurance:



Please remember that your insurance coverage is a contract between you and your insurance company and is not a substitute for payment. If you would like a more accurate estimate of what your dollar portion will be for proposed treatment, we would encourage you to contact your insurance company for that benefit information. We will gladly submit your claim to your insurance company, but your portion is due the day of treatment. After receiving payment from your insurance company, you will then receive a bill from our office if there is any remaining balance. Payment is required within 15 days of notification.

To our patients <u>without</u> insurance:

We request that all charges be paid at the time of each visit.

**A $3.00 billing fee will be added to your balance if statements are sent out. If the account becomes past due and turned over to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts. Your account being turned over to collections may result in you and anyone associated with this account being dismissed from the practice.

I understand and agree to the above policy: **X**_____ **Date: ___ /____ / ____**

Signature of Responsible Party on Account

HIPAA PRIVACY FORM

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

DATE : ___ /___ / _____

PATIENT NAME: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____

DESCRIPTION OF AUTHORITY OF LEGAL REPRESENTATIVE: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship _____

Name: _____ Relationship _____