Family Dentistry of Lowell

PATIENT INFORMATION

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help. Patient Information (Confidential):

Date: _____

Name_____ Birthdate_____

SS# _____-_____-_____ **Driver's License #** ____-_____-_____-_____-_____

Address_____ City _____ St _____ Zip _____

Home phone _____ Work phone _____ ext _____ Cell _____

E-mail address _____ *(Please print very carefully)*

Employer _____ Preferred Name _____

☐ Minor ☐ Single ☐ Married ☐ Widowed

How did you hear about our office? _____

Person to contact in case of an emergency _____ Phone _____

If patient is a minor:

Mother's Name_____
Birthdate_____
Employer_____
Work phone # _____
SS#_____

Father's Name_____
Birthdate_____
Employer_____
Work phone # _____
SS#_____

If college student, name of college_____ City _____ St____

☐ Full time ☐ Part time **Has student status been established with your insurance carrier? YES or NO**

Primary Dental Insurance Information

Name of Insured _____ DOB_____ Relationship to patient _____

SS#_____ Member ID#_____ (located on your ID card)

Insurance Carrier _____ Employer _____

Insurance Address _____City _____ St ____ Zip code _____

Insurance Phone # _____ Group # _____

Secondary Dental Insurance Information

Name of Insured _____ DOB_____ Relationship to patient _____

SS#_____ Member ID#_____ (located on your ID card)

Insurance Carrier _____ Employer _____

Insurance Address _____City _____St ____ Zip code _____

Insurance Phone # _____ Group # _____

(OVER)

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

□ yes □ no *Are you under a physician's care now?* *If yes, please explain*_____
□ yes □ no *Have you ever been hospitalized or had a major operation?* *If yes, please explain*_____
□ yes □ no *Have you ever had a serious head or neck injury?* *If yes, please explain*_____
□ yes □ no *Are you taking any medications, pills, or drugs?* *If yes, please explain*_____
□ yes □ no *Do you take, or have you taken Phen-Fen or Redux?*
□ yes □ no *Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?*
□ yes □ no *Are you on a special diet?* *Vitamin supplements*_____
□ yes □ no *Do you use tobacco?*
□ yes □ no *Do you use controlled substances?* *Height* _____ *Weight* _____

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** □ **other antibiotics** _____
□ **Codeine** □ **Acrylic** □ **Metal** □ **Latex** □ **Iodine** □ **Local Anesthetics** □ **Sedatives** □ **Barbiturates** □ **Sulfa**
□ **other** _____ *No known allergies*_____ *(Initials required)*

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

AIDS/HIV Positive	□ Yes □ No	Fainting spells/Dizziness	□ Yes □ No	Osteoporosis	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Frequent cough	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No
Anaphylaxis	□ Yes □ No	Frequent Diarrhea	□ Yes □ No	Parathyroid Disease	□ Yes □ No
Anemia	□ Yes □ No	Frequent Headaches	□ Yes □ No	Psychiatric Care	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Genital Herpes	□ Yes □ No	Radiation Treatments	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Glaucoma	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Artificial Joint	□ Yes □ No	Hay Fever	□ Yes □ No	Renal Dialysis	□ Yes □ No
Asthma	□ Yes □ No	Heart Attack/failure	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Blood Disease	□ Yes □ No	Heart Murmur	□ Yes □ No	Rheumatism	□ Yes □ No
Blood Transfusion	□ Yes □ No	Heart Pace Maker	□ Yes □ No	Scarlet Fever	□ Yes □ No
Breathing Problem	□ Yes □ No	Heart Trouble /disease	□ Yes □ No	Shingles	□ Yes □ No
Bruise Easily	□ Yes □ No	Hemophilia	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis A	□ Yes □ No	Sinus Trouble	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Spina Bifida	□ Yes □ No
Chest Pains	□ Yes □ No	Herpes	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	High Cholesterol	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Convulsions	□ Yes □ No	Hives or Rash	□ Yes □ No	Thyroid Disease	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Hypoglycemia	□ Yes □ No	Tonsillitis	□ Yes □ No
Diabetes	□ Yes □ No	Irregular Heartbeat	□ Yes □ No	Tuberculosis	□ Yes □ No
What is your A1C # _____		Kidney Problems	□ Yes □ No	Tumors or Growths	□ Yes □ No
Drug Addiction	□ Yes □ No	Leukemia	□ Yes □ No	Ulcers	□ Yes □ No
Easily Winded	□ Yes □ No	Liver Disease	□ Yes □ No	Venereal Disease	□ Yes □ No
Emphysema	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Yellow Jaundice	□ Yes □ No
Epilepsy or Seizures	□ Yes □ No	Lung Disease	□ Yes □ No		
Excessive Bleeding	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Other _____	
Excessive thirst	□ Yes □ No				

*Name of previous Dentist and location*_____ *Date of last exam*_____
Do your gums bleed while brushing or flossing ? _____ *Are your teeth sensitive to hot or cold?* _____ *Frequent headaches?* _____
Are your teeth sensitive to sweet or sour foods? _____ *Do you clench or grind your teeth?* _____ *Do you feel pain to any of your teeth?* _____
Do you bite your lips or cheeks frequently? _____ *Have you ever had complications with any extractions?* _____ *Prolonged bleeding?* _____
Do you like your smile? _____ *Have you had orthodontic treatment?* _____ *Do you wear partials or dentures?* _____
Do you have any sores or lumps in or near your mouth? _____ *Have you had head, neck or jaw injuries?* _____
Have you ever experienced any of the following problems with your jaw: Clicking _____ *Pain (joint, ear, side of face)* _____ *Difficulty chewing* _____
Difficulty in opening or closing _____*?*

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners upon my request. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

_____ _____
Signature of patient (or parent/guardian if minor) *Date*

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are offering you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you may have a copy of our notices of privacy practices.

I acknowledge that a copy of the Notice of Privacy Practices is available to me.

_____	_____	_____
Patient or Parent / Guardian Signature	**Patient Name (please print)**	**Date**

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment and the use of your name and photograph.

I consent to your disclosure of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be the type listed above.

I authorize Family Dentistry of Lowell representatives to confirm dental appointments and mail information pertaining to dental appointments.

_____	_____	_____
Patient or Parent / Guardian Signature	**Patient Name (please print)**	**Date**

Information such as appointments, treatment plans, cost, recommendations, etc. may be released to the following people:

_____ _____

_____ _____

_____ _____

For office use only.

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement: _____

_____.

An emergency situation prevented the patient from signing the Acknowledgement.

_____	_____	_____
Office Personnel Signature	**Office Personnel Print Name**	**Date**

Family Dentistry of Lowell

Dear Patient,

Your dental appointment is ***reserved*** time with the doctor and/or hygienist. Please read and sign the following:

We ask that ***two business days*** notice be given for scheduling changes and that any changes for scheduled appointments be made during our business hours by phone. Our office is open Monday, Tuesday, Thursday & Friday (subject to change). Cancellations left on the recorder after hours or communicated by email or text will be considered short notice cancellations.

Initial _____

A short notice cancellation or failing to arrive for your appointment, is subject to a fee of $25.00 or more. A history of no show or late notice cancellations could result in dismissal from the practice.

Initial _____

Patients are responsible for knowing their appointment dates and times. We send confirmation texts and emails as a ***courtesy***. To avoid getting multiple messages, ***please confirm promptly***. You will continue to receive messages and calls until the appointment is confirmed.

Initial _____

We respect your time and make every effort to seat you promptly for your appointment. We ask that you show us the same courtesy by being on time. To be fair to the patients after you, If you arrive late for your appointment, we may need to reschedule.

Initial _____

I understand the appointment guidelines for Family Dentistry of Lowell.

_____

(signature)

ADULT

Name_____ Date_____

It is our goal to educate our patients on proper dental care, overall health and nutrition. In order to do so, we ask you to please fill out this questionnaire.
This questionnaire is designed to aid us in identifying any habits that lead to dental related problems and to educate you, in order to prevent disease and achieve the best oral health.

1. Are there any special diets followed by you or any family members? Yes / No
   If so, does that affect your food intake? Yes / No
2. Would you say your diet is *good*, *fair* or *poor*?
3. List any vitamin supplements that you take_____
4. Do you frequently consume foods high in sugars? Yes / No
5. Do you snack between meals? Yes / No
   Examples:
6. Do you sip on a drink throughout the day? Yes / No
   Examples:
7. Do you drink alcohol more than 3 times per week? Yes / No
8. Do you chew on gum or suck on mints regularly? Yes / No
9. Do you frequently have dry mouth? Yes / No
10. Do you take any meds that cause dry mouth? Yes / No
11. Do you use tobacco products? Yes / No
12. Do you breathe through your *mouth* or *nose*? (Circle one)
13. Do you have fluoride in your water at home? Yes / No
14. How often do you brush? _____per_____ Floss? _____per_____
15. Are your teeth sensitive to *hot*, *cold* or *certain foods*? Yes / No
16. Has anyone ever told you that you have gum disease? Yes / No
17. Has anyone in your immediate family been treated for gum disease? Yes / No
18. Have you had any fillings in the last 3 years? Yes / No
19. Has anyone in your immediate family had fillings in the last 3 years? Yes / No
20. Have you had braces in the past? Yes / No
21. Are you undergoing Chemotherapy or Radiation Treatments? Yes / No
22. Have you been told that you snore in your sleep? Yes / No
23. Have you been told you have sleep apnea? Yes / No
24. Do you currently use or have you used in the past a C-PAP machine? Yes / No
25. Are you tired, fatigued or sleepy most days? Yes / No
26. What are the long term goals for your dental health?_____
    _____
27. Do you wish to change anything about your smile? _____
    _____