ASSOCIATES IN DENTISTRY

IMPLANTS
&
General Dentistry

860-745-2712

PATIENT INFORMATION

Patient Name : _____
Last First MI
Preferred Name _____ Birthday _____ M _____ F _____

S.S. # _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Business Phone (_____)_____

Cell Phone (_____)_____ E-Mail _____

Employer _____ Occupation_____
Can we contact you at work? _____Yes _____ No

When & Where Are Best Times To Reach You? _____

Whom May We Thank For Referring You To Our Practice? _____

Whom May We Contact In The Event of An Emergency? Name: _____

Relationship _____ Phone No. _____

INSURANCE INFORMATION

Name of Insured _____ Is insured a patient? _____ Yes _____ No

Insured's Birthdate _____ ID# _____ Group # _____

Insured's Home Address _____
Street State Zip
Insured's Employer Name _____

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insurance Plan Name _____ Telephone # _____

COSMETIC INFORMATION

Are you pleased with the appearance of your teeth when you smile? . . . . . Yes ____ No____
Do you have stains on your teeth that won't brush off? . . . . . Yes ____ No____
Are your teeth as white as you'd like them to be? . . . . . Yes ____ No____
Do you get canker sores? . . . . . Yes ____ No____
Do you have any concerns about bad breath odor? . . . . . Yes ____ No____
Do you have old black fillings or a crown with dark margins around
them you'd like replaced with the newer tooth color restorations? . . . . . Yes ____ No____
If you could change anything about the appearance of your smile, what would that be?

_____
_____
_____
_____

Have you ever had any of the following? (check boxes that apply)

Name of family physician _____ Phone _____
Date of last physical? _____

Are you under medical treatment now? . . . . . Yes ____ No____
Have you had any major operations? If so, what . . . . . Yes ____ No____
Have you ever had a serious accident involving head/mouth injuries? . . . . . Yes ____ No____
Do you smoke or use tobacco in any form? . . . . . Yes ____ No____
Are you on a diet at this time? . . . . . Yes ____ No____
Are you in general good health at this time? . . . . . Yes ____ No____
Have previous cuts healed slowly or presented other complications? . . . . . Yes ____ No____
Are you pregnant? . . . . . Yes ____ No____ Due Date:_____
Do you have a history of fainting? . . . . . Yes ____ No____
Is there any other information that should be known about your health or previous dental visits? . . Yes ____ No____

_____
_____
_____
_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date _____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

Date of last Visit: _____ Date of last x-rays: _____

Health Information

MEDICATIONS	ALLERGIES
List any medications you are currently taking and the correlating diagnosis: _____ _____ _____ Pharmacy Name: _____ Phone: (_____) _____	_____ Aspirin _____ Local Anesthetic _____ Penicillin _____ Codeine _____ Sulfa _____ Iodine _____ Latex _____ Barbiturates (sleeping pills) _____ Other: _____

Place a mark on yes or no to indicate if you have had any of the following:

Aids/ HIV	___Yes ___ NO	Epilepsy	___Yes ___ NO	Respiratory Disease	___Yes ___ NO
Anemia	___Yes ___ NO	Fainting or dizziness	___Yes ___ NO	Rheumatic fever	___Yes ___ NO
Arthritis, Rheumatism	___Yes ___ NO	Glaucoma	___Yes ___ NO	Scarlet Fever	___Yes ___ NO
Artificial Heart Valve	___Yes ___ NO	Headaches	___Yes ___ NO	Shortness of Breath	___Yes ___ NO
Artificial Joints	___Yes ___ NO	Heart Murmur	___Yes ___ NO	Sinus Trouble	___Yes ___ NO
Asthma	___Yes ___ NO	Heart Problems	___Yes ___ NO	Skin Rash	___Yes ___ NO
Back Problems	___Yes ___ NO	Hepatitis Type:	___Yes ___ NO	Special Diet	___Yes ___ NO
Bleeding abnormally	___Yes ___ NO	Herpes	___Yes ___ NO	Stroke	___Yes ___ NO
Blood Disease	___Yes ___ NO	High Blood Pressure	___Yes ___ NO	Swollen Feet or Ankles	___Yes ___ NO
Cancer	___Yes ___ NO	Jaundice	___Yes ___ NO	Swollen Neck Glands	___Yes ___ NO
Chemical Dependency	___Yes ___ NO	Jaw Pain	___Yes ___ NO	Thyroid Problems	___Yes ___ NO
Chemotherapy	___Yes ___ NO	Kidney Disease	___Yes ___ NO	Tonsillitis	___Yes ___ NO
Circulatory Problems	___Yes ___ NO	Low Blood Pressure	___Yes ___ NO	Tuberculosis	___Yes ___ NO
Congenital Heart Lesion	___Yes ___ NO	Mitral Valve Prolapse	___Yes ___ NO	Tumor of growth in Head or Neck ___Yes ___ NO	
Cortisone Treatments	___Yes ___ NO	Nervous Problems	___Yes ___ NO		
Cough	___Yes ___ NO	Pacemaker	___Yes ___ NO	Ulcer	___Yes ___ NO
Diabetes	___Yes ___ NO	Psychiatric Care	___Yes ___ NO	Vaneral Disease	___Yes ___ NO
Emphysema	___Yes ___ NO	Radiation Treatment	___Yes ___ NO	Weight loss	___Yes ___ NO

Women:

Are you Pregnant? ___Yes ___ NO Due Date: _____	Are you Nursing? ___Yes ___ NO
Taking Birth Control Pills? ___Yes ___ NO	

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date _____

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PATIENT CONSENT and PRIVACY RIGHTS (HIPAA – 4/14/2003)

CONSENT FOR TREATMENT

1. I hereby and voluntarily consent to such procedures, including diagnostic and treatment, as may be deemed necessary by Associates in Dentistry .

2. I further understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to Associates in Dentistry to make any/all changes and additions as necessary

3. I understand that I have the right to question, discuss or refuse any or all tests and/or treatments **before** the work has begun.

4. I understand that dentistry is not an exact science and, therefore, no guarantees or assurances have been made by anyone regarding the dental treatment which I have requested and authorized.

5. I understand that the final opportunity to make changes to dental work such as bridges, crowns, dentures, partials, and night guards (including shape, fit size, and color) will be **before the final cementation or insertion**.

6. I give consent to Associates in Dentistry and his associates to call in prescriptions and to consult with my health care providers.

7. I acknowledge that I have had the opportunity to read this form. My questions have been answered to my satisfaction. **I understand its contents. I can receive a copy of this form upon request.**

CONSENT TO RELEASE MEDICAL/DENTAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I authorize the release of any medical information necessary to process my insurance claims and necessary information for billing statements.
2. I authorize the release of my name to identify work sent to medical and dental laboratories.
3. I authorize and request payment directly to Associates in Dentistry of medical/dental benefits otherwise payable to me. They will not exceed Associates in Dentistry regular charges.
4. I understand that I am financially responsible to Associates in Dentistry for any deductible, co-insurance or non-covered services. I further understand that once the work is initiated, I am financially responsible.
5. I agree this authorization will cover all medical/dental services rendered until such authorization is revoked by me through written notification.
6. I agree that a photocopy of this form may be used in lieu of the original.

PATIENT NAME (PRINT) _____ Date _____

PATIENT/GUARDIAN SIGNATURE _____ Date _____

ASSOCIATES IN DENTISTRY

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DENTAL TREATMENT CONSENT FORM

☐ **1. X-RAYS** (Initials_____)

☐ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

☐ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

☐ **4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

☐ **5. CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. (Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**
I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials_____)

☐ **9. FILLINGS**
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing. (Initials_____)

☐ **10. DENTURES**
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____Date_____