

PATIENT INFORMATION

Patient Name: _____
Last First MI (Preferred Name)

Male Female Child Single Married Divorced Widowed

Social Security #: _____ Birth Date: _____ Home Phone#: _____

Address: _____
No PO Boxes Street Apartment # _____

City State Zip Code

Mailing Address : _____
If different above

Cell Phone: _____ E-Mail : _____

Responsible Party (for child or if other than above)

Name: _____ Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Address: _____
If different from above Street Apartment City State Zip Code

Employment Information

(if the patient is a child, please provide parent's employment information)

YOUR EMPLOYER

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Phone: _____ Ext: _____

SPOUSE'S EMPLOYER Spouse Name: _____

Employer Name: _____ Occupation: _____

Address: _____
Street City Zip Code

Phone: _____ Ext: _____

Dental Benefit Information (Primary Only) Required For Claim Submission

In order to submit a claim on your behalf, your insurance card is required. We will retain a copy for our records.

Insurance Plan Name: _____ Effective Date: _____ Group #: _____

Employee Name: _____ Date of Birth: _____ SSN or Alt. ID _____

Getting to Know You

Referred to us by Yellow Pages Mail Insurance Website Location Patient/Other Name: _____

Is another family member or relative a patient at our office?: _____

Person to Contact for Emergency: _____
Name Relationship Phone#: _____

Your former address: _____
Street

City State Zip Code

Closest Relative (not living with you) Name Phone Number

Street

City State Zip Code

Consent for Services

To be signed by all patients

- ◆ I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Downing to make a thorough diagnosis of _____'s dental need.
(name of patient)
- ◆ Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- ◆ I agree to use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- ◆ I understand that the fee estimates quoted for dental care can be extended for a period of six months from the date of the initial evaluation/diagnosis. Any unforeseen changes in treatment (at Doctor and/or patient discretion) may alter proposed treatment/fee fees and will be review as situations arise.
- ◆ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have made in advance. In the event payments are not received by agreed upon date, I understand that a 1-1½ % late charge (18% APR) my be added to my account. I will be responsible for any remaining balance, interest, late fees and court and/or attorney fees in the event of default.
- ◆ We try to remind patients prior to the appointment, but please do not depend on this courtesy. An appointment in this office is a contract of time reserved for you only. A missed or short notice cancellation leaves a serious void and reduces the effectiveness in caring for all patients. To avoid the broken appointment fee of \$50 per ½ hour of scheduled time, at least 24-hour (business days) advance notice is required.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Office Witness: _____

Signature of patient

Signature parent or responsible party (must be present) Relationship to Patient _____

Dental Benefits Authorization

I understand that all insurance quotes are **estimates only**. I agree to be solely responsible for ALL fees incurred regardless of insurance. In the event that insurance pays less than the estimated amount, I am responsible for the unpaid balance.

To the extent permitted under applicable law, I authorize release of any information relating to my dental claims. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Paul R. Downing, DMD, PC. A photo-copy of this document may act as an original.

Signature of patient

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed and/or received a copy of this office's Notice of Privacy Practices. _____
Signature

I authorize the release of my protected health information to Spouse Parent (s) Other _____

Signature

Date

We reserve the right to charge for appointments cancelled without 24-hour advance notice.

Patient Name _____

DENTAL HISTORY

*Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do your gums ever bleed or hurt? Yes No

Have your parents experienced gum disease
or tooth loss? Yes No

Have you noticed any loose teeth or change
in your bite? Yes No

Does food tend to become caught in between
your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails) Yes No

Mouth breath while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Patient Name _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication, drugs, pills or herbals now? Yes No

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) Yes No	Ulcers Yes No	Hepatitis A, B, C Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Glaucoma Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Contact lenses Yes No	Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Blood Transfusion Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Hemophilia Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Asthma Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Hay Fever Yes No	Liver Disease Yes No
Cortisone Medicine Yes No	Latex Sensitivity Yes No	Yellow Jaundice Yes No
Swollen Ankles Yes No	Allergies or Hives Yes No	Neurological Disorders Yes No
Stroke Yes No	Sinus Trouble Yes No	Epilepsy or Seizures Yes No
Diet (Special/ Restricted) Yes No	Radiation Therapy Yes No	Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) Yes No	Chemotherapy Yes No	Nervous/Anxious Yes No
Kidney Trouble Yes No	Tumors Yes No	Psychiatric/Psychological Care Yes No

7. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

8. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Meds. _____

Allergies _____

Doctor Signature _____ Date _____