

"A SMILE... IS A TERRIBLE
THING TO WASTE"



AUTHORITY TO TREAT

I, _____ HEREBY GRANT AUTHORITY TO:

Dr. _____ AT CARMEL COMMONS DENTAL AND ANY OTHER HYGIENIST, ASSISTANTS OR EMPLOYEES SELECTED BY HIM IN CHARGE OF MY CARE TO ADMINISTER ANY TREATMENT, TO ADMINISTER SUCH ANESTHETICS; AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF MY CASE. I AM AWARE THAT THE PRACTICE OF DENTISTRY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE AS TO THE RESULT OF TREATMENT OR EXAMINATION IN THIS OFFICE.

I UNDERSTAND THAT THE PATIENT HAS THE RIGHT TO WITHHOLD CONSENT TO A DENTAL SERVICE THAT IS DEEMED NECESSARY OR ADVISABLE BY THE DENTIST. I ALSO UNDERSTAND THAT FAILURE TO TREAT DIAGNOSED CONDITIONS WILL RESULT IN NON-TREATED OUTCOMES.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF THE RISKS AND POSSIBLE CONSEQUENCES OF THE TREATMENT PROPOSED AND SO AUTHORIZE THE ABOVE NAMED DOCTOR TO PROCEED.

SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN

DATE

I understand that I have the right and responsibility to ask questions for clarification about any recommended treatment, service or product provided by the dentist and/or his or her employee.

HIPPA PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

PATIENT NAME _____

SIGNATURE OF PATIENT/GUARDIAN _____

PATIENT BIRTHDATE _____ TODAY'S DATE _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I VERBALLY REVIEW THE MEDICAL/DENTAL AND INSURANCE INFORMATION WITH THE PATIENT

EMPLOYEE SIGNATURE _____ DATE _____

EMPLOYEE SIGNATURE _____ DATE _____

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DENTAL INSURANCE

PRIMARY DENTAL INSURANCE Co. NAME	SECONDARY DENTAL INSURANCE Co. NAME
_____ INSURANCE Co. PHONE	_____ INSURANCE Co. PHONE
_____ GROUP/PLAN/ POLICY #	_____ GROUP/PLAN/POLICY #
_____ INSURED'S NAME	_____ INSURED'S NAME
_____ RELATIONSHIP	_____ RELATIONSHIP
_____ INSURED'S EMPLOYER	_____ INSURED'S EMPLOYER
_____ INSURED'S BIRTHDAY	_____ INSURED'S BIRTHDAY
_____ INSURED'S ID#/SSN	_____ INSURED'S ID#/SSN

PAYMENT POLICIES

If the office accepts your insurance plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorized payment directly to Carmel Commons Dental for my benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorized release of any information to my insurance company.

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment options and policies for our office:

Payment by **cash, credit card, check card, or money order at the time of treatment.** As an added incentive, a **5% discount** will be applied for a **full payment** at the time of treatment on treatment plans costing \$1000 or more and/or a **10% discount** will be given for senior citizens using this payment option. Please note that there is a \$50 charge for each returned check received via mail.

We **do not** accept **checks** at time of treatment. **Patient/guardian initials:** _____

Dental fees may be charged to your **American Express, Master card, and Visa.**

Payment plans are available. Treatment plans must exceed \$1000 total repayment. Additional information is available upon request.

Fees for **emergency services** must be paid in full at the time of treatment via cash or credit card. Insurance will not be accepted during "after hours" office visits.

The charges for all services rendered are the responsibility of the patient or guardian in the case of a minor. Additional information is available upon request.

A five dollar billing fee will post to accounts with outstanding balances after 30 days. Finance charges will post to accounts with outstanding balances greater than 90 days.

A \$50 rescheduling fee may be added to the account for any appointment canceled within a 24 hour period or per patient that does not show for their scheduled appointment. **Patient/guardian initials** _____

Any **credit amount** remaining on an account longer than thirty (30) days can be exchanged for **dental services only.** I understand the above stated payment policy and agree to be financially responsible for any services rendered to me and/or my family members.

Signature of patient/parent/guardian

Date

Witness

Date

Carmel Commons Dental



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ABOUT YOU

TODAY'S DATE _____

1. NAME OF PATIENT (<i>Last, first, middle</i>) _____	2. BIRTHDATE _____ AGE _____
3. E-MAIL ADDRESS _____	4. PREFER TO BE CALLED _____
5. HOME STREET ADDRESS (<i>street, apartment</i>) _____ (<i>city, state, ZIP</i>)	6. CONTACT NUMBER(S) Home _____ Cell _____
7. EMPLOYER (<i>how long there?</i>) _____	8. SEX _____ 9. MARITAL STATUS (<i>circle one</i>) F M S M D W
10. OCCUPATION _____	11. EMERGENCY CONTACT NAME (<i>not living w/you</i>) _____
12. WORK PHONE NUMBER (<i>phone, ext</i>) _____	13. EMERGENCY CONTACT NUMBER (<i>cell, work</i>) _____
14. BEST METHOD TO REACH YOU (<i>e-mail, cell, home, work</i>) _____	15. REFERRED BY? _____
16. PHYSICIAN'S NAME _____	17. PHYSICIAN CONTACT NUMBER _____

DENTAL HISTORY

1. PURPOSE OF VISIT _____	2. PREVIOUS/PRESENT DENTIST (<i>date of last visit</i>) _____
3. SMILE Y N DO YOU LIKE YOUR SMILE? Y N WOULD YOU LIKE WHITER TEETH? Y N WOULD YOU LIKE STRAIGHTER TEETH? Y N WANT TO REPLACE DARK FILLINGS? Y N ARE ANY TEETH SENSITIVE? (<i>hot/cold</i>) Y N ANY CONCERN ABOUT YOUR SMILE? _____	4. HYGIENE HOW MANY TIMES A DAY DO YOU BRUSH? _____ Y N DO YOU FLOSS? (<i>times a week</i>) _____ Y N DO YOUR GUMS BLEED? TYPE OF BRISTLES? (<i>circle one</i>) S M H Y N HAD AN ORAL CANCER SCREENING? Y N DO YOU USE ORAL RINSES OR FLUORIDE? Y N DO YOU HAVE MOUTH ODOR? (<i>bad breath</i>) _____
5. TMJ/TMD (<i>circle one</i>) Y N DOES YOUR JAW LOCK, GET STUCK, CLICK or POP? Y N DO YOU HAVE DIFFICULTY OR PAIN WHEN OPENING? (<i>yawning</i>) Y N DO YOU HAVE FACIAL OR PAIN WHEN CHEWING, TALKING? Y N DO YOU HAVE PAIN IN OR AROUND THE EAR, CHEEK, TEMPLE? Y N DOES YOUR BITE FEEL EVEN? Y N DO YOU HAVE FREQUENT HEADACHES? Y N HAVE YOU HAD A RECENT INJURY TO YOUR HEAD, FACE OR JAW? Y N HAVE YOU PREVIOUSLY BEEN TREATED FOR A JAW JOINT PROBLEM? _____	
6. ARE YOU TAKING ANY BONE STRENGTHENING MEDICINE? IF SO WHICH ONES _____	
7. Y N DO YOU HAVE REMOVABLE TEETH? IF SO FOR HOW LONG? _____	Y N DO YOU NEED TO USE ADHESIVE? Y N CAN YOU CHEW WELL?



PAST/CURRENT MEDICAL HISTORY

- Y N ABNORMAL BLEEDING/ BLEEDING PROBLEMS
- Y N ALCOHOL/DRUG ABUSE
- Y N ANEMIA/SICKEL CELL DISEASE/SICKEL CELL TRAIT
- Y N ARTHRITIS, RHEUMATISM, OR BURSITIS
- Y N ARTIFICIAL JOINTS/VALVE
- Y N ASTHMA
- Y N BLOOD TRANSFUSION (if yes, when _____)
- Y N CANCER, CHEMOTHERAPY, RADIOTHERAPY (if yes, when _____)
- Y N CONGENITAL HEART DEFECT/VALVES PROBLEMS
- Y N DIABETES (if yes, diagnosis date _____, type _____)
- Y N DIGESTION PROBLEMS/EATING DISSORDERS/ANOREXIA/BULIMIA
- Y N EMPHYSEMA/BREATHING PROBLEMS
- Y N EPILEPSY/SEIZURES
- Y N FAINTING SPELLS
- Y N FREQUENT HEADACHES
- Y N GLAUCOMA/EYE PROBLEMS
- Y N HAY FEVER/SINUS PROBLEMS/COMMON ALLERGIES
- Y N HEART TROUBLE (if yes, diagnosis date _____)
- Y N HEPATITIS A, B or C/ LIVER DISEASE (if yes, diagnosis date _____)
- Y N HERPES/FEVER BLISTER/ ORAL ULCERS (if yes, diagnosis date _____)
- Y N HIGH OR LOW BLOOD PRESSURE (if yes, diagnosis date _____)
- Y N HIV+/AIDS
- Y N HOSPITALIZED FOR ANY REASON (if yes, when and diagnosis)
- Y N KIDNEY PROBLEMS/STONES
- Y N LUPUS
- Y N PSYCHIATRIC PROBLEM/BIPOLAR/DEPRESSION
- Y N RHEUMATIC/SCARLET FEVER
- Y N SMOKE (USE TOBACCO PRODUCTS)
- Y N THYROID PROBLEMS (if yes, diagnosis date _____)
- Y N TUBERCULOSIS (TB) (if yes, diagnosis date _____)
- Y N VENEREAL DISEASE, STD
- Y N DO YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? (if yes, why _____)
- Y N ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR NATURAL SUPPLEMENTS? (please list)
 MEDICATIONS _____ INDICATION (specify reason and doses) _____

PLEASE LIST ANY MEDICAL CONDITION(S) NOT LISTED ABOVE _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (please circle)

Aspirin	Codeine	Penicillin	Metal	Latex	Dental Anesthetic
Erythromycin	Sulfa	Tetracycline	Other _____		

FOR WOMEN

- Y N ARE YOU USING ANY BIRTH CONTROL METHOD?
- Y N ARE YOU PREGNANT? WEEKS# _____
- Y N ARE YOU NURSING?

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

SIGNATURE DATE

MEDICAL HISTORY UPDATE

Y N ANY CHANGES IN YOUR MEDICAL STATUS? EXPLAIN _____
 SIGNATURE _____ DATE _____

