Carmel Commons Dental

"A SMILE… IS A TERRIBLE THING TO WASTE"

ABOUT YOUR CHILD

Today's Date_____

1. NAME OF PATIENT (*Last, first, middle*)
_____
2. BIRTHDATE _____ AGE _____
3. E-MAIL ADDRESS
_____
4. PREFER TO BE CALLED _____
5. HOME STREET ADDRESS (*street, apartment*)
_____
(*city, state, ZIP*)
_____
6. CONTACT NUMBER(S)
Home _____
Cell _____
7. SCHOOL (*grade*)
_____
8. SEX F M
9. SSN
_____
10. HOBBIES
_____
11. MOTHER'S NAME FATHER'S NAME
_____
12. SCHOOL PHONE NUMBER (*phone, ext*)
_____
13. MOTHER CONTACT NUMBER
(M)_____(W)_____
14. BEST METHOD TO REACH PARENTS (*cell, home, work*)
_____
15. FATHER CONTACT NUMBER
(M)_____(W)_____
16. PHYSICIAN'S NAME
_____
17. MOTHER'S DOB
_____
18. PHYSICIAN'S CONTACT NUMBER
_____
19. FATHER'S DOB
_____

DENTAL HISTORY

1. PURPOSE OF VISIT
_____
2. PREVIOUS/PRESENT DENTIST (*date of last visit*)
_____

3. *SMILE*

Y N DO YOU LIKE THEIR 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? (*hot/cold*)
Y N ANY CONCERN ABOUT YOUR SMILE?
_____

4. *HYGIENE*

HOW MANY TIMES A DAY HE/SHE BRUSH? _____
Y N DOES HE/SHE FLOSS? (*times a week*) _____
Y N DOES HER/HIS GUMS BLEED?
TYPE OF BRISTLES? (*circle one*) S M H
Y N DOES HE/SHE DRINK FLUORIDE WATER?
Y N DO YOU HAVE MOUTH ODOR? (*bad breath*)

5. *HABITS* (*circle one*)

Y N DOES/DID YOUR CHILD EXPERIENCE BREAST FEED?
Y N DOES/DID YOUR CHILD HAVE DIFFICULTY OR PAIN WHEN OPENING? (*yawning*)
Y N DOES/DID YOUR CHIL CHEW ON OBJECTS OR BITE THEIR NAIL?
Y N DOES/DID YOUR CHILD CLENCH/GRIND HIS/HER TEETH?
Y N DOES/DID YOUR CHILD SUCK HIS/HER THUMB OR FINGERS?
Y N DOES/DID YOUR CHILD BREATH THROUGH HIS/HER MOUTH?
Y N DOES YOUR CHIL HAS ANY SPEECH PROBLEM?
Y N DOES/DID YOUR CHILD EVER USE(D) PACIFIER, NURSING BOTTLE, SIPPY CUPS?
Y N DOES/DID THE CHILD SUCK HIS/HER LIPS, BITE HIS/HER LIPS?

6. ARE THE CHILD'S IMMUNIZATIONS CURRENT?
IF NOT WHICH ONES _____

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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 SUPLEMENTS? *(please list)*

MEDICATIONS INDICATION *(specify reason and doses)*

_____
_____
_____

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

ARE YOU ALLERGIC TO ANY OF THT 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 _____

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DENTAL INSURANCE

PRIMARY DENTAL INSURANCE	SECONDARY 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 my insurance plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments 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, certified check 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 cancelled within a 24 hour period or per patient that does not show for his/her 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**

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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_____