PATIENT INFORMATION

Name: ______________________ Date: ______________

Address: ______________________ City: ______________ State: _____ Zip: _______

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

E-mail: ____

Preferred method of communication: ☐E-mail ☐Text ☐Cell Phone ☐Home Phone

SSN#/SIN: ______________ Birthdate: ______________ Sex: ☐Male ☐Female

Family Status (please circle): ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

If you are completing this form for another person, what is your relationship to that person?

Name: ______________________ Relationship to patient: ______________

Whom may we thank for referring you? ______________________________

FINANCIALLY RESPONSIBLE PARTY

Name: ______________________ Relationship to patient: ______________

Address: ______________________ City: ______________ State: _____ Zip: _______

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

SSN#/SIN: ______________ Birthdate: ______________ Sex: ☐Male ☐Female

Is this person currently a patient in our office? ☐Yes ☐No

INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to patient: ______________

Insured SSN#/SIN: ______________________ Insured Birthdate: ______________

Insured Employer: ______________________ Occupation: ______________

Employer Address: ______________________ City: ______________ State: _____ Zip: _______

Insurance Company: ______________________ Group Number: ______________

Insurance Identification Number: ______________ Insurance Phone Number: ______________

As a courtesy, we will file all dental claims within our office. All quotes given are only estimates. Insurance companies do not guarantee payment, and we will not know exact amounts due until your insurance company responds to the claim. Regardless of what your insurance pays, you are fully responsible for any balances due.

I authorize my insurance company to make payments directly to Mid Cities Dental on my behalf for treatment rendered. I fully understand that quoted costs are estimates only, and the patient portion may change if treatment changes or the insurance pays more or less than the estimated.

OFFICE POLICY

Mid Cities Dental has a missed appointment fee as follows:

1) Hygiene appointment with less than 24 hours' notice - $50
2) Treatment appointment with less than 24 hours' notice - $100

Signature of Patient/Parent or Guardian: ______________________ Date: ______________

MEDICAL HISTORY

Name: ______________________________ Date: ____________________

Are you under the care of a physician? ☐Yes ☐No

Please list all the names, specialty, and phone numbers of physicians who are currently providing care:

Physician	Specialty (Ex: Primary Care, Cardiologist, etc)	Phone Number

Date of last physical examination: ____________________

Have you had a serious illness, operation, or been hospitalized in the last 5 years? ☐Yes ☐No

If yes, reason: ______________________________

Please answer the following:

Acid Reflux	Yes	No	Heart Stent	Yes	No
Anemia	Yes	No	HIV Infection/ AIDS or ARC	Yes	No
Arthritis	Yes	No	Joint Replacement	Yes	No
Autoimmune Diseases (Rheumatoid Arthritis, Lupus, Scleroderma, etc)	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Blood Disorder	Yes	No	Mental Health/ Neurological Disorder	Yes	No
Cancer, Tumor, Abnormal Growth	Yes	No	Osteoporosis	Yes	No
Chemotherapy or Radiation	Yes	No	Organ Transplants	Yes	No
Diabetes Type I or II	Yes	No	Pacemaker	Yes	No
Emphysema or other Respiratory/ Lung Illnesses	Yes	No	Previous Biopsies	Yes	No
Epilepsy/ Convulsions/ Seizures	Yes	No	Sore/ Enlarged Lymph Nodes	Yes	No
Fainting or Dizzy Spells	Yes	No	Radiation or Chemo Treatment	Yes	No
Glaucoma	Yes	No	Recurrent Infections	Yes	No
Head or Neck Injury	Yes	No	Sinus Problems	Yes	No
High Blood Pressure	Yes	No	Severe Headaches/ Migraines	Yes	No
High Cholesterol	Yes	No	Severe or Rapid Weight Loss or Gain	Yes	No
Hives, Skin Rash, Hay Fever	Yes	No	Sexually Transmitted Diseases	Yes	No
Heart Abnormalities or Previous Bacterial Endocarditis	Yes	No	Stomach Problems/ Gastrointestinal Diseases/ Eating Disorders	Yes	No
Congenital Heart Disease	Yes	No	Stroke	Yes	No
Heart Valve (artificial)	Yes	No	Thyroid or Parathyroid Problems	Yes	No
Heart Valve Dysfunction	Yes	No	Tuberculosis, Measles, Chicken Pox	Yes	No
Heart Disease, Heart Attack, Heart Surgery	Yes	No	Ulcers	Yes	No

Are you currently receiving care with a physician for any medical conditions not listed above? If yes, list nature of care:

____

____

Do you need to take any antibiotic before dental care? ☐Yes ☐No Reason: ____________________

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐Yes ☐No

If so, please list all medications, herbals, supplements, and/or vitamins with their dosage and purpose:

Medication	Dosage	Purpose

(If further room is needed for medications, please use reverse.)

Are you allergic or have you had a reaction to the following?

Local anesthetics	☐Yes ☐No
Penicillin or other antibiotics	☐Yes ☐No
Sulfa Drugs	☐Yes ☐No
Aspirin, Ibuprofen, Acetaminophen	☐Yes ☐No
Codeine, Valium, or other narcotics	☐Yes ☐No
Iodine	☐Yes ☐No
Latex	☐Yes ☐No
Metals	☐Yes ☐No
Food substances or dyes	☐Yes ☐No
Other (please specify):	☐Yes ☐No

____

Women:

Are you pregnant?	☐Yes ☐No
If no, are you planning a pregnancy in the near future?	☐Yes ☐No
Are you a nursing mother?	☐Yes ☐No
Are you taking birth control pills?	☐Yes ☐No

Social History:

Do you use controlled substances (drugs)?	☐Yes ☐No
Do you use tobacco (smoking, snuff, chew, bidis)?	☐Yes ☐No
If yes, how interested are you in stopping?	☐Yes ☐No ☐ Somewhat
Do you drink alcoholic beverages?	☐Yes ☐No
If yes, about how many alcoholic beverages per a week?	______________

I certify that I have read and understand the above and that the information given on this form is accurate to the best of my knowledge. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify the doctor of changes in health and medication. 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.

______________________________ ______________

Signature of Patient/Parent or Guardian Date

______________________________ ______________

Signature of Doctor Date

DENTAL HISTORY

Name: ______________________ DOB: ______________

Chief Complaint/ Reason for this visit: ______________________

When was your last dental visit? ______________ What was done then? ______________

How often did you visit the dentist before then: ______________________

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

Face and Oral Tissues

☐Yes ☐No Have you had any head, neck, or jaw injuries? If yes, please explain: ______________

Have you ever experienced any of the following problems in your jaw?

☐Yes ☐No Clicking ☐Yes ☐No Difficulty opening or closing

☐Yes ☐No Pain (joint, ear, side of face) ☐Yes ☐No Difficulty chewing

☐Yes ☐No Do you have frequent headaches?

☐Yes ☐No Do you have any sores or lumps in or near your mouth?

Periodontal

☐Yes ☐No Do your gums bleed while brushing or flossing?

☐Yes ☐No Have you had a history of gum disease or gum surgery?

Teeth

☐Yes ☐No Are your teeth sensitive to hot, cold, sweet, or sour liquids/foods?

☐Yes ☐No Do you clench or grind your teeth?

☐Yes ☐No Do you have any broken or chipped teeth?

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

Esthetics

☐Yes ☐No Do you have discoloration of teeth/tooth?

☐Yes ☐No Are you interested in whitening?

☐Yes ☐No Have you had previous orthodontic treatment?

☐Yes ☐No Are you interested in orthodontic treatment? i.e. ClearCorrect, Invisalign, Conventional Braces

Approach to Dentistry

☐Yes ☐No Have you had any bad experiences at dental offices?

☐Yes ☐No Are you nervous about dental treatment?

Smile Survey

Check each of the following that applies to you:

	Bite feels off		Visibly missing teeth
	Teeth out of line		Stained or discolored teeth
	Spacing or gaps between teeth		Chipped or broken tooth
	Crowded teeth		Dark fillings that show
	Dark lines around old crowns		Excessive gum tissue

☐Yes ☐No Is there anything you would like to change about your smile? If yes, please explain:

____

☐Yes ☐No Do you have any questions or concerns I should be aware of? If yes, please explain:

____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐Yes ☐No

May we leave a message on your answering machine at home or on your cell phone? ☐Yes ☐No

May we discuss your medical condition with any other party? ☐Yes ☐No

If YES, please list the name of party/parties allowed:

____

____

This consent was signed by:

____
(Print Name Please)

______________________________ ____________________
Signature of Patient/Parent or Guardian Date

______________________________ ____________________
Signature of Witness Date