GENERAL INFORMATION – ADULT

Please fill in completely.

A. Name_____ Preferred Name:_____

Birth Date_____ Soc. Security No._____

B. Home Address_____ City, State, Zip _____

Phone #_____ Cell Phone # _____ Email _____

C. Employed by_____ Occupation_____ How Long _____

D. Business Address_____ Phone_____

E. Spouse's Name_____ Employed By_____

Occupation_____ How Long_____ Business Address_____

F. Person Responsible for Account_____ Soc. Security No._____ Birth Date_____

G. Whom may we thank for referring you to our office? _____

If from an advertisement where did you see the ad?_____

H. If you have no phone, please list a number where you may be reached to verify appointments, et cetera: _____

Phone Number _____

I. Children in family_____ (Names and ages) _____

_____

a. Do you know that fluoride can help to prevent decay in children's teeth? _____

b. Are your children taking fluoride drops or tablets each day?_____

c. Have they been given topical treatments of fluoride?_____

J. Name of your physician (MD) _____ City _____

When last seen _____ For what reason _____

K. Former Dentist _____ City _____

When last seen _____ For what reason _____

REASON FOR THIS VISIT:

Examination, X-rays (and study models, if necessary)_____ Emergency treatment_____

PAYMENT OF PROFESSIONAL FEES:

(Routine dental services, emergency care, must be paid for at time of treatment.)

A. Cash
B. Check
C. Credit Card (MasterCard, Visa, Discover, and CareCredit accepted)

Date_____ Your Signature_____

WHAT IS BEST DAY AND TIME FOR DENTAL APPOINTMENTS?_____

(The answers to these questions are for our records only, and will be considered confidential. Thank you for your cooperation.)

MEDICAL-DENTAL HISTORY FORM

Name:_____

What is your general state of health? Excellent_____ Good _____ Fair _____ Poor _____

Have you been under a physician's care during the last two years? _____

Have you been treated in a hospital in the past three years? _____

Have you had major surgery? _____

Are you allergic to: ☐ Penicillin, ☐ Codeine, ☐ Local Anesthetics, ☐ Other _____

Have you ever taken Fosamax, Boniva, Actonel, or other medications containing bisphonates?_____

Do you require Premedication (antibiotic) prior to your dental appointments?_____

If female: Are you pregnant or nursing? _____

Please check yes to all that apply:

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Asthma	☐	☐	Psychiatric Care	☐	☐
Anemia/Sickle Cell	☐	☐	Liver Disease	☐	☐	Persistent Cough	☐	☐
Arthritis	☐	☐	Chemotherapy	☐	☐	Irregular Heartbeat	☐	☐
Artificial Joint	☐	☐	Osteoporosis	☐	☐	Snoring	☐	☐
Kidney Problems	☐	☐	Heart Trouble/Disease	☐	☐	Hepatitis B or C	☐	☐
Thyroid Disease	☐	☐	Stroke	☐	☐	High Blood Pressure	☐	☐
Chest Pains	☐	☐	Nervousness/Anxious	☐	☐	Artificial Heart Valve	☐	☐
Heart Pacemaker	☐	☐	Organ Transplants	☐	☐	Sinus Trouble	☐	☐
Tobacco Use	☐	☐	Diabetes	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐
Fibromyalgia	☐	☐	High Cholesterol	☐	☐	Congenital Heart Lesions	☐	☐
Dry Mouth	☐	☐	Fainting Spells/Dizziness	☐	☐	Depression	☐	☐
Radiation Therapy	☐	☐	Bruise Easily	☐	☐	Tuberculosis	☐	☐
Rheumatic Fever	☐	☐	Hay Fever	☐	☐	Heart Surgery	☐	☐
Epilepsy or Seizures	☐	☐	Heart Murmur	☐	☐	Sleep Apnea	☐	☐

Blood Pressure (office to take) _____

Do you have any condition, disease, or problem not previously listed? _____

_____

_____

Please list all the medications you are taking, including over the Counter Drugs and Herbs

Medications:	Dosage:	Times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If additional space is needed please use the back of this form.

DENTAL HEALTH

Name: _____

When was your last dental visit? _____ How often did you see your dentist?_____

Are you having any dental problems that require immediate attention? _____

Do you have frequent headaches? _____ Ear aches? _____ How often? _____

Is there anything that will cause your muscles to be tired or sore or cause headaches? _____

Are your jaw joints painful or tender? _____ If yes pleases describe _____

Have you had trauma to you jaw? _____ Do your jaw joints pop or click or grate? _____

Do you jaws ever feel tired or ache? _____ Have you ever been told you have TMJ? _____

Do you clench or grind you teeth? _____

Does your bite feel comfortable? _____ Have you noticed any change in your bite? _____

Have you ever been told you have periodontal disease? _____ Have you ever had periodontal treatment? _____

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

Have you noticed any changes in your teeth? _____

Do you have loose teeth? _____ Worn teeth? _____ Broken or chipped teeth? _____ Food traps? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you lose fillings or break fillings? _____ Do you usually have cavities? _____

Have you ever had orthodontic treatment? _____ When? _____

How do you feel about the appearance of you smile? _____

What improvements would you like to make in your mouth? _____

_____

Please add anything you feel is important: _____

_____

Signature: _____ Date: _____

Personal Dental Needs Survey

Please circle the level of fear you have about your dental visits. (10 being the greatest fear.) 1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit.

____ Sedative medications ____ Patient education materials

____ Nitrous Oxide ____ Music and earphone (Please list the type of music.) _____

Are you concerned about the following? (Yes or No):

____ Existing discomfort? ____ Whitening your teeth? _____ Replacing old silver fillings? _____ Mouth odor?

____ Prevention of decay? ____ Appearance of my smile? _____ Recurring/untreated gum disease? _____ Other_____

When discussing my treatment plan, I prefer: _____ The big picture _____ Detail by detail

When evaluating my smile, it's most important: _____ What I see _____ What others see

Answers are for our records only and are considered confidential. Thank you!

Appointment Reminders

We will contact you in advance to confirm your appointments. Please check which method you would prefer to be contacted:

- ☐ Phone call _____
- ☐ E-mail _____
- ☐ Text _____

Cell phone carrier _____

Appointment Cancellation Policy

When we schedule an appointment for you, we are setting aside a dedicated chair and time slot just for you. If you must reschedule your appointment, please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who may be waiting to get in.

There will be a charge of $50 for not showing up for scheduled appointments with no notice. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt.

I have read and understand the Appointment Cancellation Policy.

Patient Name_____

Patient Signature_____ Date_____

HIPAA PRIVACY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient *(if filling out for someone else):*_____

Date:_____

I give permission for _____ to have access to my dental records.

Spring Valley Dentistry
W502 State Road 29; PO Box 190
Spring Valley, WI 54767