Patient Information Form

Please complete the following information

Date: _____

Name: _____ Hm Phone: _____ Wk Phone: _____
Cell Phone: _____ E-mail address: _____ Pager #: _____
Home Address: _____ City: _____ St: _____ Zip Code_____
Social Security #: _____ Date of Birth: (Month/Day/Year)_____
Circle One: Married Single Divorced Widowed Driver's License #: _____
Occupation: _____ Employer: _____

Your Spouse

Spouse Name: _____ Birthday (Month/Day/Year) _____
Home Address: _____ Hm Phone: _____ Wk Phone: _____
City, State, & Zip: _____ Social Security #: _____
Employer: _____ Occupation: _____

Dental Insurance

- Dental Insurance Company: _____
- Address: _____
- City, State, Zip Code: _____
- Telephone: _____
- Group or Policy #: _____

Getting to Know You

Is any other member of your family a patient at our office? _____
Their name? _____ Relationship? _____
Whom can we thank for referring you to our office? _____
Nearest Relative not living with you: _____ Phone: _____
Physician: _____Phone: _____
Whom may we contact in case of an emergency? _____ Phone: _____

Account Information

Who is responsible for this account? _____Phone: _____
Address (if different than above) _____ City: _____ St: _____Zip: _____
Employer: _____ Bus. Address: _____ Bus. Phone: _____
Dental Insurance Co: _____ Phone #: _____ Policy #: _____
I will be paying by cash _____ check: _____ credit card: _____

I authorize release of any information relating to my dental claim. I authorize payment directly to the Dentist of the group insurance benefits otherwise payable to me.

Signature of responsible party: _____

Health History Form

Correctly answering the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____Birth date_____ Age_____
Why are you now seeking dental treatment? _____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now? ..... YES NO
2. Are you under the care of a physician? ..... YES NO
   If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious illness? ..... YES NO
   If yes, please explain_____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... YES NO
5. (Women) Are you pregnant? If so, give due date _____ YES NO
6. Do you use tobacco in any form? If yes, how much _____ YES NO
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... YES NO
8. Do you have or have you ever had any of the following? Please circle any that apply

GENERAL
Marked weight change
Night sweats
Persistent fever

SKIN
Eruptions (rash) hives
Change in skin color

EYES
Visual change
Glaucoma

EARS
Loss of hearing
Ringing in ears

NOSE
Frequent nosebleeds
Sinus problems

THROAT
Soreness/hoarseness

BLOOD
Bruise easily
Anemia
Blood transfusion

BONE/MUSCLES
Arthritis/rheumatism
Artificial joints/limbs

HEART/BLOOD VESSELS
Rheumatic fever
Heart murmur
Chest pain/discomfort
Heart attack/trouble
Shortness of breath
Swelling of ankles
High blood pressure
Congenital heart disease
Mitral valve prolapse
Artificial heart valve
Pacemaker
Heart surgery
Other

RESPIRATORY
Tuberculosis
Emphysema
Asthma/hay fever
Persistent cough
Sputum production (phlegm)
Cough up bloody sputum
Difficulty breathing
while lying down

ENDOCRINE
Diabetes
Family history of diabetes
Thyroid condition/goiter
Other

DIGESTIVE SYSTEM
Hepatitis
Jaundice
Ulcers
Change in appetite
Black, bloody or pale stools

URINARY
Kidney disease
Increase in frequency
of urination(night)
Burning on urination
Urethral discharge
Bloody urine
Venereal disease

OTHER
Latex Sensitivity
Radiation therapy
Chemotherapy
Tumors or growths
Cancer
HIV+
AIDS

NERVOUS SYSTEM
Stroke
Headaches
Convulsions/epilepsy
Numbness/tingling
Dizziness/fainting
Psychiatric treatment

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	YES	NO	Aspirin or codeine	YES	NO
Barbiturates/sedatives/sleeping pills	YES	NO	Sulfa Drugs	YES	NO
Penicillin/other antibiotics	YES	NO	Other allergies _____		

10. Are you taking any of the following?

Antibiotics/sulfa drugs	YES	NO	Tranquilizers	YES	NO
Blood thinners	YES	NO	Insulin/other diabetes drugs	YES	NO
Blood pressure medication	YES	NO	Recreational drugs	YES	NO
Thyroid medicine	YES	NO	Digitalis/other heat medication	YES	NO
Cortisone/ steroids	YES	NO	Nitroglycerin	YES	NO
Antihistamines/allergy drugs/			Aspirin	YES	NO
cold remedies	YES	NO	Other medication_____		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition, or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, please explain_____

12. Physician's Name _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderate_____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH			**TEETH**		
Bleeding, sore gums	YES	NO	Loose teeth	YES	NO
Unpleasant taste/bad breathe	YES	NO	Sensitive to hot	YES	NO
Burning tongue/lips	YES	NO	Sensitive to cold	YES	NO
Frequent blisters, lips/mouth	YES	NO	Sensitive to sweets	YES	NO
Swelling/lumps in mouth	YES	NO	Sensitive to biting	YES	NO
Ortho treatments (braces)	YES	NO	Food impaction	YES	NO
Biting cheeks/lips	YES	NO	Clenching/grinding	YES	NO
Clicking/popping jaw	YES	NO	Shifting of teeth	YES	NO
Difficulty opening or closing jaw	YES	NO	Change in bite	YES	NO

ORAL HYGIENE

Do you use the following?

Brush	YES	NO	How often do you brush _____
Dental floss	YES	NO	Brush is: Soft _____ Medium _____ Hard _____
Fluoride rinse	YES	NO	

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent or Guardian _____Date_____

NEW PATIENT CONSENT FOR TREATMENT

1. I hereby authorize the Doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of (name of patient) _____'s needs.

2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the 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.

4. I give consent to the Doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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 been made. If insurance is filed for me, I agree to pay the amount insurance does not cover within 30 days.

Patent (Parent/Guardian) Signature Date

Witness Signature Date

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file.

Our practice continually looks for advances to ensure that we are providing the optimum level or oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: patients age 18-39
High risk: patients age 40 and older; tobacco users (any age, any type within 10 years)
Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and or alcohol use); previous history of oral cancer

We have recently incorporated **Oral ID** into our oral screening standard of care. We find that using Oral ID along with a standard oral cancer examination improves the ability to indentify suspicious areas at their earliest stages; Oral ID is similar to proven early detection procedures for other cancers such as mammography, Pap smear and PSA. Oral ID is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Oral ID exam will be provided to you on your re-care appointments.

This enhanced examination is recognized by the American Dental Association. Dr Covell and the team consider it such an important asset to your overall dental health that **there is no fee for this examination.**

YES. I authorize the clinician to perform the Oral ID exam along with the standard oral cancer examination. I understand that the fee for this service is included in my re-care appointment annually.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the Oral ID exam at this time.

Print name: _____

Signature: _____ Date: _____