PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height: ☐
For Office Use Only BP: ☐ Heart Rate: ☐			Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Acid Reflux
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Angina Pectoris
☐	☐	Anxiety/Mental Disorder
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS

Y	N	Conditions
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A, B, C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Rheumatic Fever
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Y	N	Conditions
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

NEW PATIENT QUESTIONNAIRE

Name: _____ **Date:** _____

What is your primary dental concern? _____

Do you have any pain or discomfort? **Y I N**

Where? (upper, lower, left, or right) _____

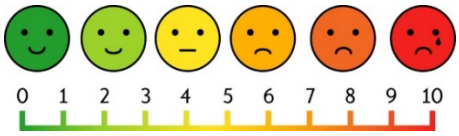
Please describe it: _____

Do you have dental anxiety? **Y I N**

How long has it been since your last dental cleaning? _____

Have you ever seen a periodontist or had a “deep cleaning”? **Y I N**

On a scale of 1-10, how would you rate the condition of your teeth?



_____

Are you interested in straightening your teeth? **Y I N**

Do you wear any dental appliances (i.e. retainer, nightguard, denture)? **Y I N** If yes, what?

_____

Please circle any of the following that are of concern to you:

Bleeding Gums	Rough Areas or Worn Edges	Chipped/Broken Teeth
TMJ Clicking/Jaw Popping	Food Trap	Cavities/Tooth Decay
Frequent Headaches	Unpleasant Breath	Clenching/Grinding
Sensitive Teeth	Discolored/Stained Teeth	Difficulty Opening
Loose Teeth	Crowding	Missing Teeth

How often do you brush? _____ Is your toothbrush electric or manual? _____

How often do you floss? _____

Is there anything that you eat or drink that you think could be affecting the health of your teeth?

_____

Have you ever been told you need to pre-medicate? **Y I N** If yes, what for? _____

Are you able to lay flat? **Y I N**

Do you have any interest in getting Botox or lip filler? **Y I N**

Padonia Dental Associates

Informed Consent

Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office, recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contraindicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to ensure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected nonvital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

Informed Consent

I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high-speed dental equipment.

Padonia Dental Associates

Informed Consent

Potential Risks and Limitations of Dental Treatment

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care.

_____ _____

Sign Date

Padonia Dental Associates

Office Policy

TO OUR PRIVATE INSURANCE PATIENTS:

As a courtesy to you, we will be happy to submit for pre-authorization and/or payment to all insurance companies with a completed and signed insurance form.

Due to escalating overhead and increasing paperwork, we will initially ask for your estimated coinsurance payment. Please understand that this is only an estimate and is based on the accuracy of the information provided to us by your insurance carrier. We will not carry balances unpaid by your insurance carrier longer than sixty (60) days after the initial submission of claims. At that time, you will be responsible for paying your balance in full and be reimbursed directly from your insurance carrier. We reserve the right to pursue all delinquent accounts via a third-party collection agency or attorney. Ninety (90) days after the date of service all unpaid balances will be sent to collections. It is your responsibility to make our office aware of any extenuating circumstances regarding an outstanding balance.

To keep the rising cost of insurance premiums down, employers negotiate certain clauses and frequency limits with your insurance carrier. As a third party, our office is not always given all the specifics on your policy by your insurance carrier. Some of these clauses may include but are not limited to; missing tooth clause, frequency and/or age limitations (for things such as exams, x-rays, fluoride, sealants, fillings, etc.)

Additionally, if you have two insurances there may be a coordination of benefits clause. It is your responsibility to be aware of your policy. Please familiarize yourself with your dental benefits to ensure you are aware of deductibles, time restraints, annual maximums and your percentage of financial responsibility.

It is important that you fully understand that the ultimate responsibility for payment is yours.

ALL PATIENTS:

We require all patients over the age of 18 to provide us with their social security number. Though many insurance companies have unique identification numbers, they are subject to change when your insurance changes. When insurance is involved, we ask you to remember that we are extending credit to you by collecting only your percentage or coinsurance payment and billing your insurance company for the balance. In addition, we ask you to remember that your name and date of birth are not always enough to uniquely identify you for records purposes. If you prefer not to make this information available to us, we will require cash payment at the time of your visit.

All patients are responsible for any copayment or payment in full at time of service. Please remember that it is your responsibility to be aware of your insurance benefits including your

Padonia Dental Associates

insurance contracts maximum benefit and your deductible. It is also your responsibility to notify our office a minimum of 24 hours or one business day prior to your appointment when you have an insurance change. You may be asked to pay for your appointment if the new insurance information is not given to the front desk accordingly.

Endodontic (root canal) therapy may be necessary after treatment of teeth having existing deep fillings or decay close to the nerve. This could occur on teeth having no previous symptoms.

All patients under the age of 18 MUST be accompanied by a parent or custodial guardian for the duration of their appointment to receive dental treatment.

We reserve the right to charge for broken or missed appointments without 24-hour notice.

A fee of $15 per 15 minutes may be assessed for failure to notify our office of your cancellation without 24-hour notice.

A $50 service charge will be assessed for all returned checks.

A service charge of 3% will be applied to all credit card transactions.

A service charge of 5% will be applied to all CARECREDIT transactions.

I understand that Padonia Dental Associates, L.L.C., reserves the right to pursue delinquent account via a third-party collection agency or attorney. In the event Padonia Dental Associates, L.L.C., forwards my bill for collection, I agree to pay for collection and/or legal services and additional thirty (30%) of the amount owed. You agree we and a third-party collection agency may contact you by telephone or text message at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you to service your account or collect any amount owed to us.

I have read and fully understand the terms stated above.

_____ _____

Signature Date

Padonia Dental Associates, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

I authorize Padonia Dental Associates, LLC to discuss personal treatment and finances with the following individual(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Patient Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign.
□ Communication barriers prohibited obtaining the acknowledgement.
□ An emergency situation prevented us from obtaining acknowledgement.
□ Other (Please Specify)

_____
_____
_____