HEALTH/ DENTAL HISTORY

Name_____ Date_____

How do you wish to be addressed _____ Date of Birth _____

Reason for today's visit _____

Former dentist_____ Reason for leaving _____

Date of last dental visit_____ Reason for last dental visit_____

How often do you brush? _____ How often do you floss? _____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS OR CONCERNS? (Circle all correct responses)

Bad breath	Y N	Food collection between teeth	Y N	Sensitivity to cold	Y N
Bleeding gums	Y N	Grinding of teeth	Y N	Sensitivity to hot	Y N
Locking jaw	Y N	Loose teeth	Y N	Sensitivity to sweets	Y N
Pain in jaw joint	Y N	Broken fillings	Y N	Sensitivity to biting	Y N
Toothaches	Y N	Swollen gum or face	Y N	Broken tooth	Y N

Have you ever had gum surgery? Y N If yes, when? _____ Do you **Smoke/ Chew (circle one)?** **Y N**
Physician's Name _____Phone _____Date of last exam_____
Allergies to Medications:

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐
Other_____

Are you being treated for a current medical condition? **Y N** *List condition*:_____
Have you had any serious illness or operations? **Y N** *Describe*:_____
List current medications you are taking:_____
Are you currently taking **Bone Density medications? Y N** (circle one) If yes, what? _____
Men: Currently taking any ED medications? **Y N** (circle one) If yes, what? _____
Women: Are you pregnant/ trying to get pregnant? **Y N** Taking oral contraceptives? **Y N** Nursing? **Y N**

Do you have, or have you had, any of the following?

AIDS/ HIV Positive	**Y**	**N**	Cortisone Medicine	**Y**	**N**	Hepatitis A	**Y**	**N**	Renal Dialysis	**Y**	**N**
Alzheimer's Disease	**Y**	**N**	Diabetes	**Y**	**N**	Hepatitis B or C	**Y**	**N**	Restless Leg Syndrome	**Y**	**N**
Anaphylaxis	**Y**	**N**	Drug Addiction	**Y**	**N**	Herpes	**Y**	**N**	Rheumatic Fever	**Y**	**N**
Anemia	**Y**	**N**	Easily Winded	**Y**	**N**	High Blood Pressure	**Y**	**N**	Rheumatism	**Y**	**N**
Angina	**Y**	**N**	Emphysema	**Y**	**N**	High Cholesterol	**Y**	**N**	Scarlet Fever	**Y**	**N**
Arthritis/Gout	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**	Hives or Rash	**Y**	**N**	Shingles	**Y**	**N**
Artificial Heart Valve	**Y**	**N**	Excessive Bleeding	**Y**	**N**	Hypoglycemia	**Y**	**N**	Sickle Cell Disease	**Y**	**N**
Artificial Joint	**Y**	**N**	Excessive Thirst	**Y**	**N**	Irregular Heartbeat	**Y**	**N**	Sinus Trouble	**Y**	**N**
Asthma	**Y**	**N**	Fainting Spells/Dizziness	**Y**	**N**	Kidney Problems	**Y**	**N**	Sleep Apnea	**Y**	**N**
Back Problems	**Y**	**N**	Frequent Cough	**Y**	**N**	Leukemia	**Y**	**N**	Sleep Apnea Appliance	**Y**	**N**
Blood Disease	**Y**	**N**	Frequent Diarrhea	**Y**	**N**	Liver Disease	**Y**	**N**	Spina Bifida	**Y**	**N**
Blood Transfusion	**Y**	**N**	Frequent Headaches	**Y**	**N**	Low Blood Pressure	**Y**	**N**	Stomach/Intestinal Disease	**Y**	**N**
Breathing Problems	**Y**	**N**	Genital Herpes	**Y**	**N**	Lung Disease	**Y**	**N**	Stroke	**Y**	**N**
Bruise Easily	**Y**	**N**	Glaucoma	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Swelling of Limbs	**Y**	**N**
Cancer	**Y**	**N**	Hay Fever	**Y**	**N**	Osteoporosis	**Y**	**N**	Thyroid Disease	**Y**	**N**
Chemotherapy	**Y**	**N**	Heart Attack/Failure	**Y**	**N**	Neck Problems	**Y**	**N**	Tonsillitis	**Y**	**N**
Chest Pains	**Y**	**N**	Heart Murmur	**Y**	**N**	Pain in Jaw Joints	**Y**	**N**	Tuberculosis	**Y**	**N**
Cold Sores/Fever Blisters	**Y**	**N**	Heart Pacemaker	**Y**	**N**	Parathyroid Disease	**Y**	**N**	Tumors or Growths	**Y**	**N**
Congenital Heart Disorder	**Y**	**N**	Heart Trouble/Disease	**Y**	**N**	Psychiatric Care	**Y**	**N**	Ulcers	**Y**	**N**
Convulsions	**Y**	**N**	Hemophilia	**Y**	**N**	Radiation Treatments	**Y**	**N**	Venereal Disease	**Y**	**N**
						Recent Weight Loss	**Y**	**N**	Yellow Jaundice	**Y**	**N**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____

REGISTRATION

Welcome and thank you for selecting us as your dental health care professionals!

PATIENT INFORMATION

Name_____ Date _____

Parent's name (IF MINOR) _____

Address street_____city_____zip code_____

Birthdate _____ Age _____ Gender _____ SS# _____

Home phone _____ Email _____ May we call you at work? Y N

Employer _____ Cell phone _____

Occupation _____ Work Phone _____

How did you find out about us? _____

IN AN EMERGENCY, who should we notify? _____ Phone _____

DENTAL INSURANCE INFORMATION

Name of person responsible for account _____

Relationship to patient _____ Birth date _____ Social Sec # _____

Address _____

Person responsible employed by _____

Business address _____

Business phone _____

Insurance company _____

Insurance company address _____

Insurance company phone _____

Name of dental plan _____

Group # _____

Is patient covered by additional dental insurance? Y N (If yes, list on back)

RELEASE:

*I give permission for my dentist and his clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.
*I assign dental benefit payments to be paid directly to Springs Dental Care, P.C. from my insurance company.
I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.
*I understand that I may be charged a 1.5% per month finance charge if my balance goes beyond 30 days.

PATIENT'S OR GUARDIAN'S SIGNATURE _____DATE_____

WELCOME TO OUR PRACTICE

SPRINGS DENTAL CARE, PC

We want to thank you for selecting us to take care of your dental needs. We are pleased to serve you, and our desire is to provide you with high quality dental care. Below is an explanation of payment policies. If you have any questions, please don't hesitate to ask.

We make every effort to keep down the cost of your dental care. You can help by paying at the time of your visit. Below are the payment options available:

1. **Cash or Check-** The account is paid in full at each visit.
2. **Credit Card-** We accept
3. **Insurance -** As a courtesy to you, we can file your insurance claims. Your deductible and co-payments are due at the time of service. In order to keep our fee down we are unable to bill you for services after insurance has paid. *Remember, insurance is not a guarantee of payment and you are responsible for paying any balance not covered by the insurance company, including all fees considered above your insurance company's maximum allowed benefit.*
4. **Payment Plans-** We offer in-house payment plans for up to three months and also accept CareCredit Making care possible...today.

A 1.5 % finance charge per month will be added to unpaid balances after 30 days. There will be a $25.00 service charge on all returned checks. ***If you need to change your reserved appointment, please give us 48 hours advanced notice so that we have time to fill the open appointment time, otherwise we will need to charge a $ 50.00 failed appointment fee. For any sedation appointments, we need at least 4-5 business days advanced notice, otherwise a fee equal to sedation cost will be applied on account.***

Authorizations

I authorize Dr. Richard A. Cea/ Dr. Ivy H. Webb, to release any information concerning my case to my insurance company. I have read the above information and understand my obligations regarding payment. This is to acknowledge signature on file for any insurance claims where authorization is necessary and to accept this office's financial policies.

SIGNED _____ DATE _____

GENERAL CONSENT

While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**. Dental materials and medications may trigger allergic or sensitivity reactions._____ (Read and initial)

2. **Long-term numbness (paresthesia)**. Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness. _____ (Read and initial)

3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in predisposed patients, precipitate a TMJ disorder._____
(Read and initial)

4. **Sensitivity in teeth or gums, infection, or bleeding**. _____ (Read and initial)

5. **Swallowing or inhaling small objects**. _____ (Read and initial)

Please understand that the longevity of our work also depends on your home care and routine maintenance with our office. By signing this form you acknowledge that you understand when a restoration of any kind is placed, we cannot stand behind our work if you do not follow through with proper home care and regular dental check-ups in our dental office. *If you do not return for your recommended oral health care maintenance appointments in the time frame we have established*, any treatment needed to replace or repair the restoration will be at the patient's expense.
While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ _____
Patient's signature/ Parent's signature (If minor patient) Date

_____ _____
Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

_____
Signature

_____
Date

***You may refuse to sign this acknowledgement**

ADDITIONAL DISCLOSURE AUTHORIZATIONS

In addition to the disclosures described in the Privacy Practices, I hereby specifically authorized the disclosure of my protected health information to those listed below.

Any member of my immediate family	**Yes___ No___**
Spouse only	**Yes___ No___**
Other (please specify) _____	**Yes___ No___**

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 acknowledgement
___An emergency situation prevented us from obtaining acknowledgement
___Other (please specify)