PATIENT DENTAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH** _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES ☐ NO ☐

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do any of your teeth feel painful	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you experienced any of the following problems		
Clicking in your jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your jaw	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Have you ever worn a bite plate or other appliance	☐	☐
Have you had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following Extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, give the date they were placed _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

_____ _____

DOCTOR'S SIGNATURE **DATE**

DOCTOR'S COMMENTS _____

PRINT FORM

MEDICAL HISTORY

NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments:

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 OR PARENT/GUARDIAN (if minor) _____ DATE _____

PRINT FORM

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

Please note: Email/text reminders are for appointment purposes ONLY. We respect your privacy and will never sell your information to any third party.

CHECK APPROPRIATE BOX

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

CHECK APPROPRIATE BOX

☐ MALE ☐ FEMALE

SS# _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ STATE OF ISSUE _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT OR PARENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE# _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ **YES** ☐ **NO** ***IF YES, COMPLETE THE FOLLOWING:***

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR **DATE**

Notice of Privacy Practices Acknowledgement

Potrykus Family Dentistry LLC
Neal Potrykus DDS * Jason J Potrykus DDS
www.potrykusfamilydentistry.com
contactus@potrykusfamilydentistry.com

I, understand that, under the Health Insurance Portability and Accountability Act of 1998 (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 healthcare 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.

OFFICE POLICIES – these policies are a base line standard for treatment and practice.

Our office *requires* all our patients to have 1 complete dental exam by the dentist yearly, this is not negotiable and is for your health and safety as well as the safety and compliance of the office staff. The ADA, in collaboration with the FDA, developed recommendations for dental radiographic examinations to serve as an adjunct to the dentist's professional judgment of how to best use diagnostic imaging. Radiographs can help the dental practitioner evaluate and definitively diagnose many oral diseases and conditions. Radiographs and other imaging modalities are used to diagnose and monitor oral diseases, as well as to monitor dentofacial development and the progress or prognosis of therapy. [www.ada.org] Our office recommends dental x-rays on a yearly basis. Our office has a 24 hour cancellation/no show policy. You may be charged a *minimum* of $40.00 for a cancelation less than 24 hours before you schedule appointment time or for a no show/last minute cancellation appointment.. Messages received by email/text/answering machine after hours will be subject to cancellation fees. The final decision is at the disquisition of the dentist based on patient compliance history and situation for the cancelation/no show. This office charges interest on accounts over 60 days. Signed records release consent will be required for the transfer or duplication of dental records.

I acknowledge that I have read and can request a full copy of the Notice of Privacy Practices and office policy containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change is Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 uses 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 wish to allow my private health information and account information to be released as necessary for billing, payment or appointment scheduling purposes to: (example: spouse, parent, children, POA or other provider automatically – list by name please. If no one then list NONE)

_____

Appointment Reminders: We may use or disclose your personal or health information to provide you with dental appointment reminders unless specifically requested not to.
Examples of use: appointment reminders on an answering machine, antibiotic reminders, appointment reminder postcards, email correspondence, text messages.

☐ YES, I want communication or reminder messages left for me using any of the following: landline, cell phone, work phone, email or postcards

☐ NO, I do not want reminder messages left for me. I do understand there may be a charge for failed, no show or < 24 hr notice cancellations of appointments and I accept responsibility to keep track of my scheduled appointment dates and times with no reminders from the dental office.

Patient Name: _____

Signature: _____ Date: _____
Relationship to patient: ☐ Self ☐ Spouse ☐ Other: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
O Individual refused to sign: _____
O Communications barriers prohibited obtaining the acknowledgement
O An emergency situation prevented us from obtaining
O Other: _____.
Staff Signature: _____ Date: _____
Document Modified: 1/15/2020