DENTAL PATIENT INFORMATION FORM

Reason for Today's Visit: _____

Name: _____ Sex: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How would you like your appointments confirmed? Call Text Email

Email Address: _____

Home Address: _____

State: _____ City: _____ Zip: _____

Patient SS# (required): _____ Date of Birth: _____

Driver's License #: _____ State: _____ Exp. Date: _____

Marital Status: Married Divorced Legally Separated Single Widowed

Full-time Student? Yes No Name of School: _____

Whom may we contact in case of emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____

Date of last dental exam: _____ Name of previous treating dentist: _____

Did you sustain an injury at work?

□ Yes □ No

Are you covered under an employer or union policy?

□ Yes □ No

Are your injuries accident related?

□ Yes □ No

Is your spouse or other family member employed?

□ Yes □ No

Are you currently employed?

□ Yes □ No

Do you have a secondary or medical insurance policy?

□ Yes □ No

DENTAL INSURANCE INFORMATION

Name of insured: _____

Relationship to patient: _____

Policy holder date of birth: _____

Policy holder social security #: _____

Dental Insurance Carrier Name: _____

Dental Insurance Carrier Address: _____

Dental Insurance Carrier Phone: _____

Identification card present upon encounter: Yes No

Insured's Employer Name: _____

Insured's Employer Address: _____

Insured's Employer Phone: _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, physician's name:_____

Have you been previously diagnosed with sleep apnea? Yes No

If yes, do you use a C-PAP? Yes No

Have you been tested for sleep apnea? Yes No

Have you been previously diagnosed with TMJ or TMD? Yes No

Have you received previous treatment for TMJ or TMD? Yes No

Allergies (circle all that apply):

Penicillin/Amoxicillin Latex Aspirin Tetracycline Sulfa Drugs

Other Allergies: _____

Have you ever had a C. difficile infection or colitis? Yes No

Medications

Please list all of the medications you are taking:

_____

_____

_____

_____

Do you have a history of tobacco use? Yes No If yes, how many years? _____

If yes, circle which apply: Cigarettes Cigars Pipe Smokeless tobacco Other

Do you have a history of vaping? Yes No

Medical marijuana use? Yes No

History of recreational drug use? Yes No

Medical History Continued

Have you been diagnosed with or do you currently have any of the following conditions or diseases?

Heart Attack	Y N	Thyroid Problems	Y N	Cancer	Y N
Pacemaker	Y N	Kidney Problems	Y N	Shingles	Y N
Heart Murmur	Y N	Liver Problems	Y N	Hepatitis	Y N
Rheumatic Fever	Y N	Respiratory Problems	Y N	HIV	Y N
Mitral Valve Prolapse	Y N	Sinus Problems	Y N	Arthritis	Y N
Artificial Heart Valves*	Y N	Stomach Problems	Y N	Diabetes	Y N
Heart Disease	Y N	Psychiatric Illness	Y N	Leukemia	Y N
Heart Defect*	Y N	Anxiety/Depression	Y N	Anemia	Y N
Heart Failure	Y N	Alcohol Abuse	Y N	Headaches	Y N
Chest Pains	Y N	Substance Abuse	Y N	Neck Pain	Y N
Stroke	Y N	Temporomandibular Joint Disease/Disorder	Y N	Glaucoma	Y N
Organ Transplant*	Y N	Tuberculosis	Y N	Fainting/Seizures	Y N
Scarlet Fever	Y N	Sexual Transmitted Disease/Infection	Y N	High Cholesterol	Y N
Infective Endocarditis*	Y N	Asthma	Y N	High Blood Pressure	Y N
Radiation Therapy	Y N	Difficulty Breathing	Y N	Low Blood Pressure	Y N
Chemotherapy	Y N	Artificial Bones/Joints*	Y N	Bleeding problems	Y N
Back Problems	Y N	Emphysema	Y N	Osteoporosis**	Y N

*Has a physician told you that you need to take antibiotics prior to dental work? Yes No

** If you have a history of osteoporosis, have you ever taken medications in the bisphosphonate class, such as alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva)? Yes No

Please list any major surgeries you have had and the date:_____

_____

Any medical condition other than those listed above: _____

Women Only:
Are you pregnant? Yes No Nursing? Yes No

I attest that the information provided is complete and accurate to the best of my knowledge,

Signature: _____ Date: _____

DENTAL HISTORY

Past or Present History of (circle all that apply):

Accidental injury to teeth/ mouth	Blisters on lips	Blisters in mouth
Blisters or burning of tongue	Chew on one side of mouth	Clench/ grind teeth
Dental fractures	Dry mouth	Growths/ lesions in mouth
Gums swollen, tender /bleeding	Head, neck, jaw pain	Lip or cheek biting
Loose teeth or broken fillings	Mouth breathing	Orthodontic treatment
Nitrous Oxide	Periodontal treatment	Sensitivity to hot/cold

How often do you floss? _____

How often do you brush your teeth? _____

Are you in pain at this time? _____

For how long have you been in pain? _____

Is your pain due to an accidental injury or accident? _____

Explain:_____

Is there anything else you would like us to know concerning your dental health or dental history?

_____

_____

_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

I am aware that a copy of my insurance identification card will be made available and a copy kept in my records.

I am responsible for updating this information if and when there are changes. I understand that co-payments are due at the time services are rendered and if the account is not paid in full, that I will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting my account.

I authorize Mountain View Dental's staff to perform any necessary services needed during diagnosis and treatment I also authorize Mountain View Dental to release any information required to process insurance claims.

Please Print Name: _____

Signature: _____ Date: _____

NO SHOW/BROKEN APPOINTMENT POLICY

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone. When you schedule an appointment, a room is reserved, records are prepared, and special instruments readied for your visit. When you make an appointment, please be sure that you will be able to keep it. Morning appointments may be best for more complicated procedures. Like many offices, this office does call to confirm your appointment. If you do not confirm through our automated system, the front office staff will also call you. There will be a charge of $25-$75 (depending on the length of the appointment) for a broken appointment or cancellation with less than 24 hours' notice and the appointment will not be rescheduled until the balance is paid.

Please Print Name: _____

Signature: _____ Date: _____

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 _____

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

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify) _____

COMPOSITE FILLING CONSENT FORM

It has been explained to me that the composite (white) fillings are the restorative material of choice replacing silver because the composite bonds better to the teeth resulting in less breakage, less hot and cold sensitivity, and is more aesthetically pleasing.

I HEREBY GIVE PERMISSION TO Mountain View Dental to place composite fillings for any restorative procedures to be done. I am fully aware and understand that I will be responsible for any balance on my account not covered by insurance.

Name _____

Patient's Signature _____ Date _____

Email and Text Message Communication Consent/Registration

Our dental office can send emails and text messages to remind you about your appointments and to confirm them, in addition to phone calls. If you wish to receive emails and/or text messages about your appointments please complete this form.

We value your privacy and allowing us to communicate with you by email or text message, the office or its service provider will contact you with appointment reminders and to confirm appointment. You always have the option out at any time. Please select an option below:

- Please sign me up to receive emails and/or text messages about my appointments.
- I do NOT wish to be contacted by email (Text messages only).
- I do NOT wish to be contacted by text message (Email only).
- I do NOT wish to be contacted by either email or text message.

I give Mountain View Dental permission to send messages to be by email and/or text message as means of communication as indicated by my selection above.

Signature:_____

Printed Name:_____

Date:_____

For office use only:

- Consent revoked: Date/Initials: _____/_____
- Possible reassigned number: Date/Initials:_____/_____