



COBBLESTONE PARK
FAMILY DENTAL

GETTING TO KNOW YOU

PATIENT NAME _____ SOCIAL SECURITY NUMBER _____ - _____ - _____ DOB ____/____/____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (____) _____ - _____ SECONDARY PHONE (____) _____ - _____ EMAIL _____

MARITAL STATUS: SINGLE MARRIED CHILD DRIVERS LICENSE AND STATE _____

DIVORCED SEPARATED WIDOWED

PRIMARY INSURANCE COMPANY _____ GROUP # _____ SUBSCRIBER # _____

SECONDARY INSURANCE COMPANY _____ GROUP # _____ SUBSCRIBER # _____

Please note: Providing the above contact information (address, phone numbers, and email address) gives Cobblestone Park Family Dental permission to contact you using the media indicated concerning appointments, newsletters and other business matters. We will not share your contact information.

RESPONSIBLE PARTY _____ SOCIAL SECURITY NUMBER _____ - _____ - _____ DOB ____/____/____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (____) _____ - _____ SECONDARY PHONE (____) _____ - _____ EMAIL _____

MARITAL STATUS: SINGLE MARRIED CHILD DRIVERS LICENSE AND STATE _____

DIVORCED SEPARATED WIDOWED RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY EMPLOYER _____ OCCUPATION _____ WORK PHONE (____) _____ - _____

BUSINESS ADDRESS _____ CITY, STATE, ZIP _____

SPOUSE'S NAME _____ SOCIAL SECURITY NUMBER _____ - _____ - _____ DOB ____/____/____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (____) _____ - _____ SECONDARY PHONE (____) _____ - _____ EMAIL _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____ WORK PHONE (____) _____ - _____

BUSINESS ADDRESS _____ CITY, STATE, ZIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (please only check one)

Who selected this office? SELF SPOUSE PARENT EMPLOYER

Where did you find the phone number to this office? REFERRED BY A FRIEND OR RELATIVE INSURANCE PLAN DIRECT MAILING SIGN BY BUILDING OTHER _____

*If referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge _____ (initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out the procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date _____ Relationship to patient _____



MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	HPV (Human Papilloma Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Lesions (Congenital)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Currently	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (head/neck)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Percodan	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Valium	<input type="checkbox"/>	<input type="checkbox"/>
Darvon	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
									Other _____		

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	<input type="checkbox"/>	<input type="checkbox"/>	Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>	Boniva	<input type="checkbox"/>	<input type="checkbox"/>
Fosomax	<input type="checkbox"/>	<input type="checkbox"/>	Herbal	<input type="checkbox"/>	<input type="checkbox"/>
Reclast	<input type="checkbox"/>	<input type="checkbox"/>	Supplements		

Are you under a physician's care? What for?

What medications are you currently taking?

Family Physician _____ Phone Number _____

Do you smoke or use tobacco products?
How much? _____
For how long? _____

Please share the following dates:
-last cleaning _____ -last dental exam _____ -last complete x-rays _____

CONSENT

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Signature _____ Date _____ Relationship to patient _____



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Getting to know your smile!

NAME _____ DATE _____

1. What are you hoping to accomplish during your appointment today? _____

2. Have you had an experience that left you unhappy with any previous dental care? If yes, please explain. _____

3. Where would rate your current dental health on a scale from 1-10? _____

4. Are you noticing any sensitivity to cold, hot, sweets or pressure or biting? _____

5. What would you change about your smile if you could? _____

6. Are you happy with the color of your teeth? _____

7. Have you ever had a sleep study completed? _____

8. Do you experience ringing in your ears, headaches or jaw joint pain? _____

9. Do you have a history of periodontal treatments?

10. Do you have any missing teeth? _____ If yes, how long have they been missing? _____

Are you interested in replacing the missing teeth? _____

11. Do you currently wear any partials or dentures? _____ If yes, how old are they? _____

12. Do you have any crowns or bridges? _____ If yes, how old are they? _____

13. How did you hear about us? _____



FINANCIAL TERMS AND CONDITIONS

This office depends on the reimbursement from the patient for the costs incurred in their cases. The financial responsibility of each patient must be determined before treatment begins as a condition for treatment by this office. Financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be made at the time of service.

If I carry insurance, I understand that this office will prepare my insurance forms, assist in making collections from the insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumptions that charges will be paid by an insurance company. Benefits and eligibility will be verified and discussed prior to treatment. In the event the insurance under or over pays, I understand that I am responsible for the remaining balance or can expect a refund.

_____ I understand that all dental services furnished to me are my financial responsibility.

_____ I understand not all services are a covered benefit. Benefits vary due to policy and insurance provider.

_____ It is patient responsibility to verify their own insurance coverage.

_____ Fees for non-covered services, deductibles, and co-payments are DUE at the time of treatment.

_____ We file your insurance as a courtesy to you, but ultimately you are responsible for any charges incurred at the time of service.

_____ Insurance companies do not provide us with complete access of payment rules; therefore, any quote of out-of-pocket fees you are presented with today, is ONLY an estimate.

Assignment of insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office accruing to me under my contract. I understand that the fee estimate listed for this dental are can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I grant my permission to you, or your assignee, to telephone me at home or at my place of employment to discuss matters related to this form.

I have read the above conditions and agree to their content.

Print Name: _____

Signature: _____ Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*****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}

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____ authorize the following person (s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}

{Relationship}

{Please Print Name}

{Relationship}

{Please Print Name}

{Relationship}

Please check if you would like a copy of Cobblestone Park Family Dental Notice of Privacy Practices []

Emergency Contact: _____

Name

Phone Number

Relationship