PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pill or drugs? What? _____ Ever taken fen-phen? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives. Discuss _____

Do you now have or have you ever had any of the following? Please circle the appropriate letter Y=YES, N=NO.
* If yes to any of the starred conditions, please call prior to appointment…pre-medication may be required.

	Yes No		Yes No		Yes No		Yes No		Yes No
Heart Trouble/Disease	Y N	Bruise Easily	Y N	Emphysema	Y N	Yellow Jaundice	Y N	Cold Sores	Y N
Heart Murmur*	Y N	Anemia	Y N	Tuberculosis	Y N	Kidney Problems	Y N	Fever Blisters	Y N
Irregular Heartbeat	Y N	Excessive Bleeding	Y N	Cancer	Y N	Renal Dialysis	Y N	Herpes	Y N
Angina/Chest Pain	Y N	Sickle Cell Disease	Y N	Radiation Treatment	Y N	Thyroid Disease	Y N	Stroke	Y N
Heart Attack/Failure	Y N	Hemophilia	Y N	Chemotherapy	Y N	Parathyroid Disease	Y N	Convulsions	Y N
Congenital Heart Disorder	Y N	Leukemia	Y N	Stomach/Intestinal Disease	Y N	Arthritis/Gout	Y N	Epilepsy or Seizures	Y N
Mitral Valve Prolapse*	Y N	Recent Blood Transfusn	Y N	Ulcers	Y N	Rheumatism	Y N	Fainting or Dizziness	Y N
Scarlet Fever	Y N	Swelling of Limbs	Y N	Recent Weight Loss	Y N	Pain in Jaw Joints	Y N	Glaucoma	Y N
Rheumatic Fever*	Y N	Lung Disease	Y N	Frequent Diarrhea	Y N	Cortisone Medicine	Y N	Tumors or Growths	Y N
Artificial Heart Valve*	Y N	Breathing Problem	Y N	Diabetes	Y N	**Artificial Joint***	Y N	Nervousness	Y N
Heart Pace Maker*	Y N	Shortness of Breath	Y N	Excessive Thirst	Y N	Venereal Disease	Y N	Psychiatric Care	Y N
Heart Surgery	Y N	Frequent Cough	Y N	Hypoglycemia	Y N	**AIDS**	Y N	Alzheimer's Disease	Y N
High Blood Pressure	Y N	Hay Fever	Y N	Liver Disease	Y N	**HIV Positive**	Y N	**Allergies (Medicines)**	Y N
Low Blood Pressure	Y N	Sinus Trouble	Y N	**Hepatitis A (Infectious)**	Y N	Genital Herpes	Y N	Allergies (Pollen/Dust)	Y N
Blood Disease	Y N	**Asthma**	Y N	**Hepatitis B or C**	Y N	**Drug Addiction**	Y N	Hives or Rash	Y N
Unexplained Fever	Y N	Bloody Sputum	Y N	Night Sweats	Y N				

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____

PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT.# CITY STATE ZIP
Email address _____

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK # CELL#

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____
(SS# or Certificate #)

Has any member of your immediate family ever been treated in our office? ☐ YES ☐ NO Name: _____
How did you hear about our office? ☐ Friend/Family _____ ☐ Internet Search
Yellow Pages: ☐ Verizon/Superpages ☐ YellowBook ☐ Local Pages
Other: _____

FAMILY INFORMATION

Fill in both shaded blocks for minor child. Fill in appropriate shaded block for adult.

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MM/DD/YY) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MM/DD/YY) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals.

X _____
___Adult Patient ___Father/Husband ___Mother/Wife ___Guardian

_____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please check one

☐ Patient ☐ Father (or Husband)

☐ Guardian ☐ Mother (or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO

☐ Payment in full at each appointment (cash / personal check)

☐ Payment in full at each appointment (credit card)
VISA MC AMEX DISCOVER
Card # _____ Exp Date _____

SERVICE CHARGE

If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Dental Treatment Consent Form

All patients complete 1 thru 4 below, and 5 thru 13 as needed

1. **WORK TO BE DONE**

   I understand that I am having the following work done: Fillings ____, Bridges ____, Crowns ____, Extractions ____, Impacted teeth removed ____, General Anesthesia ____, Root Canals ____, Other _____ **(Initials _____)**

2. **DRUGS, MEDICATION AND SEDATION**

   I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking. The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed. **(Initials _____)**

3. **CHANGES IN TREATMENT PLAN**

   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. **(Initials _____)**

4. **REMOVAL OF TEETH**

   Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, exposed sinuses, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand bleeding could last for several hours. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **(Initials _____)**

5. **CROWNS (permanent or Stainless Steel),BRIDGES, VENEERS AND BONDING**

   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. **(Initials _____)**

6. **DENTURES-COMPLETE OR PARTIAL**

   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. A "try in" is not always possibly for immediate dentures. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures and that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

   (Initials_____)

7. **ENDODONTIC TREATMENT (ROOT CANAL) (PULPOTOMY)**

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. **(Initials _____)**

8. **PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work. **(Initials _____)**

9. **IMPLANTS**

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist. **(Initials _____)**

10. **BLEACHING**

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment. **(Initials _____)**

11. **SEDATION (Nitrous Oxide, Oral Conscious Sedation and/or Intraveneous Sedation)**

I understand that analgesia can cause nausea and vomiting, and have been advised that the patient is not to eat or drink 2-4 hours prior t treatment. I further understand that the fee for such services are my responsibility including all arrangements to be made through my insurance. I agree and hereby give my consent. **(Initials _____)**

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature of Responsible Party_____ **Date**_____

Witness: _____ **Date:**_____

ABOUT FINANICAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered. Payment and/or co-pays for **custom prosthetic services** are due at the time of the appointment when we take the initial impressions and are **non-refundable**. We accept cash, checks, MasterCard/VISA, Discover, American Express and Care Credit (on approved credit). If you have a dental benefit plan, we will bill your claims for you at no charge. If you assign benefits to us, you will only be required to pay your **estimated** portion as treatment is completed. We will provide you with an estimate based on our knowledge of your particular dental plan at the time of your examination. In the event that the insurance carrier rejects your claim, or the amount paid is less than what was estimated, you will be responsible for full payment of the balance.
Balances older than 30 days may be subject to additional service charges of 1.5% per month or a minimum of $3.00 per month, whichever is greater. There is a $25.00 charge for a returned check. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice, at a rate of $25.00 per hour missed.
We will gladly discuss your proposed treatment and answer any questions relating to your dental coverage. You must realize however that:

1. Your dental benefit program is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees may not be covered in full by the maximum allowance determined by your dental carrier. Occasionally carriers will set their reimbursement rates lower than the "UCR" (usual, customary and reasonable) fees for this region in order to save costs. This causes a higher "out of pocket" expense to the patient. That portion that the insurance carrier does not pay is due by you.
3. Not all services are a covered benefit in all contracts.
4. You are responsible to us for all fees for services rendered to you and your family members.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand that dentistry is not an exact science, and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee of assurance has been made by anyone regarding this dental treatment which I am requesting and authorizing. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me, or my family.

I hereby authorize any of the doctors or dental auxiliaries of HB Dental to proceed with and perform the dental treatment that has been/will be explained to me. I understand that I will be given an estimate subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of all dental fees.
I agree to pay any attorney's fees, or court costs that may be incurred to satisfy that obligation.
I agree to that a photocopy of this authorization shall be valid and effective as the original forever. I am of legal age and legally competent to make this assignment for myself or for any of my dependents.

I will also inform the doctors or dental auxiliaries of any changes in my medical history, insurance and/or address without fail.

I certify that I have had an opportunity to read and fully understand the terms and words within the above and have had the opportunity to have any questions answered to my satisfaction.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____