

ADULT PATIENT INFORMATION

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Address: _____

Street Apartment #

City State Zip Code

E-Mail Address: _____

Phone (Home): _____ (Work): _____ Ext: _____

(MOBILE): _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Do you have dental Insurance? YES NO, (If Yes, please fill out Dental Insurance Information below.)

Insurance Information

PRIMARY INSURANCE

Name of Insured Subscriber: _____ Is insured a patient? Yes No

Last First MI

Subscriber ID #: _____ Plan Group #: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Company Name: _____

SECONDARY INSURANCE

Name of Insured Subscriber: _____ Is insured a patient? Yes No

Last First MI

Subscriber ID #: _____ Plan Group #: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Company Name: _____

DENTAL HISTORY

1. What is the reason for your visit today? _____
2. Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____
3. What was done on your last dental visit? _____
4. Previous Dentist's Name _____
5. How often do you have dental examinations? _____
6. How often do you brush your teeth? _____ How often do you floss _____
7. What other dental aids do you use? (electric toothbrush, toothpick, waterpik, etc.) _____

8. Do you have any dental problems now? YES NO
If yes, please describe: _____

- | | | | |
|--|--|--|--|
| Are any of your teeth sensitive to: | | Have you ever had: | |
| Hot or cold? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Braces? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sweets? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tooth Extraction | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Biting or chewing? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Gum surgery? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Any mouth odors or bad tastes? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Bite adjusted? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you frequently get cold sores, blisters or
any other oral lesions? | <input type="checkbox"/> YES <input type="checkbox"/> NO | A bite plate or mouth guard? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | Serious injury to mouth or head? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | If so, please describe including cause _____ | |

- | | | | |
|---|--|-----------------------------------|--|
| Do your gums bleed or hurt? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Have you parents experienced gum disease
or tooth loss? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Have you experienced: | |
| Have you noticed any loose teeth or change
in your bite? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Clicking or popping of the jaw | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does food tend to become caught in
between your teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Pain (joint, ear, side of face)? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you have dental implants? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Difficulty in opening or closing? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you use dentures? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Difficulty in chewing? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | Neck aches or shoulder aches? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | Sore muscles? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

- | | | | |
|--|--|---|--|
| Do you: | | Are you satisfied with your teeth's
appearance? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Clench or grind your teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Would you like to keep all of your
teeth all of your life? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bite your lips or cheeks regularly? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you feel nervous about having
dental treatment? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails) | <input type="checkbox"/> YES <input type="checkbox"/> NO | If so, what is your biggest concern?
_____ | |
| Have tired jaws, especially in the morning? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Smoke/chew tobacco? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Have you ever had an upsetting dental experience?
If yes, please describe _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

- Is there anything else about having dental treatment that you would like us to know? YES NO
If yes, please describe _____

I understand the above medical and dental information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

AUTHORIZATION FOR TREATMENT

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies some risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice and for the payment to be applied directly to any outstanding balance on my account.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare options, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available in our office and on our website, and we encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You have the right to revoke this consent at any given time by giving us written notice of your revocation submitted to Dr. Halloran. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination and treatment plan.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Dentist Signature _____ Date _____