

Date _____ **GETTING TO KNOW YOU AS OUR PATIENT**

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F	Drivers License and State
Primary Insurance Company _____	Group _____	Subscriber _____

Responsible Party NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ()
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address	City	State Zip

How did you hear about our Office?
(check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office?
 Referred by a friend Yellow Pages Insurance Plan Welcome Wagon
 Other TV/Radio Ad Newspaper Ad Direct Mailing Sign by Building

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

TERMS AND CONDITIONS

This office, regardless upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, independent financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, the dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to the Office benefits according to me under my policy. I understand that the fee estimate listed for the dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to 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 agree that in the event that either the office or I initiate any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____
 Last Visit _____ Date of last cleaning _____
 Previous Dentist _____

What problems have you had with past dental treatment?

Are you nervous about seeing a dentist? Yes No If yes, please tell us why: _____
 How often do you brush? _____ Do you floss? Yes No How often? _____

(Please circle each)
 Y N I scratch or grind my teeth during the day or while sleeping. Y N My gums feel tender or swollen
 Y N My gums bleed while brushing or flossing. Y N I have problems eating.
 Y N I like my smile. Y N I have had orthodontics.
 Y N I prefer tooth-colored fillings. Y N I have had a facial or jaw injury.
 Y N I avoid brushing part of my mouth due to pain. Y N I want my teeth straight.
 Y N I want my teeth whiter. Y N I want my teeth whiter.

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor
 Do you or have you had any of the following? please circle Y for yes or N for no.

- | | | |
|---|---|---|
| 1. Y N Heart Disease | 22. Y N Liver Disease | 36. Y N AIDS |
| 2. Y N Heart Murmur/Valvular Valve Prolapse | 23. Y N Jaundice | 37. Y N Immune Suppressed Disorder |
| 3. Y N Stroke | 24. Y N Hepatitis Type _____ | 38. Y N Hearing Loss |
| 4. Y N Congenital Heart Lesions | 25. Y N Diabetes | 39. Y N Fainting Spells |
| 5. Y N Rheumatic Fever | 26. Y N Excessive Urination and/or Thirst | 40. Y N Glaucoma |
| 6. Y N Abnormal Blood Pressure | 27. Y N Infectious Mononucleosis (Mono) | 41. Y N History of Emotional or Nervous Disorders |
| 7. Y N Anemia | 28. Y N Herpes | |
| 8. Y N Prolonged Bleeding Disorder | 29. Y N Arthritis | |
| 9. Y N Tuberculosis or Lung Disease | 30. Y N Sexually Transmitted/Venereal Disease | |
| 10. Y N Asthma | 31. Y N Kidney Disease | |
| 11. Y N Hay Fever | 32. Y N Tumor or Malignancy | |
| 12. Y N Sinus Trouble | 33. Y N Cancer/Chemotherapy | |
| 13. Y N Epilepsy/Seizures | 34. Y N Radiation Treatment | |
| 14. Y N Ulcers | 35. Y N History of Drug Addiction | |
| 15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other _____ | | |
| 16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____ | | |
| 17. Y N I have consumed alcohol within the last 24 hours. | | |
| 18. Y N I usually take an antibiotic prior to dental treatment. | | |
| 19. Y N Have you ever taken Fen-Phen or Redux? _____ | | |
| 20. Y N Have you ever had major surgery? Year _____ Type of operation: _____ | | |
| 21. Y N Do you have any other medical problem or medical history NOT listed on this form? Year _____ Type of operation: _____ | | |

Are you allergic to any of the following? Please list all medications you are currently taking: _____
 Please circle Y for yes or N for no

- | | |
|---|-----------------|
| 44. Y N Aspirin | Condition _____ |
| 45. Y N Ibuprofen | Condition _____ |
| 46. Y N Sulfonamides/Sulfites/Sulfides | Condition _____ |
| 47. Y N Penicillin | Condition _____ |
| 48. Y N Codeine | Condition _____ |
| 49. Y N Latex, Metals, Plastics | Condition _____ |
| 50. Y N Local Anesthetics (Novocaine) | Condition _____ |
| 51. Y N Other Medications - Which ones? _____ | Condition _____ |

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____
 Name _____ Relationship _____ Phone _____
 Initial medical/dental health reviewed by: _____ Date _____
 Doctor's Signature _____ Patient's Signature _____
 Date _____ Date _____

GETTING TO KNOW YOU AS OUR PATIENT

Consent to Disclose Private Healthcare Information

For Treatment, Payment, and/or Healthcare operations

I _____, hereby authorize and consent for Greenville Family Dentistry to release any and all medical, dental, and or psychological reports or records, including but not limited to: medical/dental notes, physician narratives, office notes, operative notes, discharge summaries, Doctor's/Dentist's orders, Nurse's notes, lab reports, test results, physical therapy, progress notes, patient progress reports, diagnosis, post operative diagnosis, pathology reports, X-rays, and any records reflecting treatment for substance abuse, mental illness, AIDS, HIV, alcohol abuse, including any X-rays, diagnostic studies, lab slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental conditions, treatment, care, or hospitalizations, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

I understand that the operations of the office of Greenville Family Dentistry, is being visually and orally recorded by a virtual private network. I hereby authorize and consent to such recording.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other healthcare options.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters

I further understand that I have the right to review Greenville Family Dentistry's privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signature _____ Date _____

General Consent for Treatment

We are required to obtain your consent from contemplated or proposed dental treatment or oral surgery. Please read this form carefully and we encourage you to ask us about anything that you do not understand.

1.) I hereby authorize and direct Greenville Family Dentistry or any of its subsidiaries, assisted by licensed dentists and/or dental auxiliaries of their choice to perform upon me, or my child the following dental treatment or oral surgery procedure including the necessary or advisable local anesthesia, x-rays, or diagnostic aids.

2.) In general terms, the dental procedures may include on or a number of the following:

- Cleaning of the teeth and application of topical fluoride
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- Stainless Steel crowns for children
- The replacement of missing teeth with a dental prosthesis (crown, partial, etc)
- Extraction (removal) of one or more teeth that cannot be saved
- Treatment of diseased or injured oral tissues (hard or soft)
- Treatment of malposed (crooked) teeth and/or developmental abnormalities
- The use of sedative medications and/or Nitrous oxide to control apprehension and/or disruptive behavior

I understand that none of the above procedures will be performed without discussing the necessity with me first. I am advised that good results are expected, however the possibility and nature of complications cannot be accurately anticipated. Therefore, no guarantee can be given to me regarding treatment. I further understand and authorize the doctor to perform any necessary treatment that in his judgment will be in the best interest of my or my child's health once treatment has been initiated.

3.) Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedure, medications and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function organs, and scarring. I understand and accept that complications may require medical assistance, hospitalizations and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent.

Patient Name _____ Date _____

Signature of Patient _____