Issaqueena Prosthodontics

implant, esthetic, and reconstructive dentistry — Craig A. Horton, DMD, MS

Who referred you to our office _____ Social Security # _____ Today's Date _____

Patient's Name _____ Birthdate _____

Address _____ City _____ ST____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager _____ E-Mail _____

Employer _____ City _____ Occupation _____

Name of Parent / Partner/ Spouse / Guardian _____ Birthdate _____
(circle one) Social Security # _____

Address if different _____ City _____ ST_____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Employer _____ City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

PRIMARY DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

SECONDARY DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

By Signing Below:

- I understand that all charges incurred are payable in full at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I authorize my insurance company to pay the dentist all insurance benefits rendered.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

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DENTAL HISTORY

- *What are your reasons for visiting our office?* _____
  _____
- Last Dental Visit and Reason for Visit_____

Past Dental History (check all previous dental services received)

- ☐ Dental Exam with X-rays
- ☐ Tooth extraction / oral surgery
- ☐ Restorations (Fillings)
- ☐ Partial Dentures (Removable)
- ☐ Crown / Bridgework (Fixed)
- ☐ TMJ (temporomandibular joint) Treatment
- ☐ Dental Implants
- ☐ Complete Dentures
- ☐ Periodontal Treatment (gum treatment)
- ☐ Endodontic Treatment (root canal treatment)
- ☐ Orthodontic Treatment (braces)
- ☐ Other – *Please Explain*

_____
_____
_____

Previous Dental Experiences

- ☐ Unpleasant Experience with dentist(s) in past (please describe): _____
- ☐ Pleased with Previous dental experience

Self-Analysis of Oral Health (please check any problems that you currently have)

- ☐ Bad teeth (Cavities)
- ☐ Crooked teeth
- ☐ Bad Bite: Teeth don't feel like they fit together correctly
- ☐ "Dry Mouth" (not enough saliva)
- ☐ Frequent sores in mouth or on lips
- ☐ Teeth painful to hot, cold, sweets
- ☐ Bleeding Gums
- ☐ Swelling in mouth or jaws on occasion
- ☐ Bad taste in mouth or bad breath
- ☐ Loose or drifting teeth
- ☐ Severe toothaches
- ☐ Other *(please describe)*

_____
_____
_____

Attitudes about Dentistry

	Yes	No
Most People will eventually lose their teeth?	☐	☐
Good Dental Care can prevent tooth loss?	☐	☐
Do you only see the dentist for emergency care?	☐	☐
Do you brush everyday?	☐	☐
Do you floss everyday?	☐	☐

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			OFFICE USE ONLY
PATIENT'S NAME		DATE OF BIRTH	PRE-MED Yes 0 No 0
PHYSICIAN'S NAME	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE	COMMENTS:
MOST RECENT VISIT TO PHYSICIAN	REASON		
HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? 0 GOOD 0 FAIR 0 POOR			DATE _____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	0	0
Have you been hospitalized within the last year? If yes, explain:	0	0
Have you had a serious illness or operation within the last year? If yes, explain:	0	0
Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:	0	0
Have you ever been advised to take antibiotics (penicillin, etc.,) before a dental appointment? If yes, explain:	0	0

Do you now or have you had any of the following cardio-vascular diseases? **yes** 0 **no** 0

If yes, check any that apply:

0 Heart disease
0 Heart attack_____
0 Coronary bypass
0 Angina
0 Mitral valve prolapse
0 Hardening of the arteries
0 High blood pressure
0 Stroke_____
0 Heart murmur
0 Congestive heart failure
0 Rheumatic fever or rheumatic heart disease
0 Congenital heart defects
0 Prosthetic (artificial) heart valves
0 Pacemaker. If yes, date of placement _____
0 High blood pressure
0 High cholesterol
0 Shortness of breath after mild exercise
0 Shortness of breath when you lie down
0 Swelling of ankles
0 Chest pain upon exertion
0 Abnormal bleeding or extended clotting time
0 Frequent or unexpected nose bleeds

Diabetes **yes** 0 **no** 0

If yes, do you require insulin?
Type _____ Dose_____

Artificial joint(s) **yes** 0 **no** 0

If yes, which joint(s)
_____

Hepatitis **yes** 0 **no** 0

If yes, check type:
0 Type A
0 Type B
0 Type C
0 Other
0 Non-specific type
0 Don't know

0 Required a blood transfusion
If yes, when _____
0 HIV positive
0 Have reason to suspect you have been exposed to the HIV virus

Tuberculosis (TB) **yes** 0 **no** 0

0 Had a TB test?
0 A cough lasting more than three weeks
0 Cough up blood

Check any that apply;

0 Allergies
0 Alzheimer's
0 Anemia
0 Angina
0 Asthma
0 Arthritis
0 Autoimmune
0 Blood Disorder
0 Cancer
0 Chemo Therapy
0 Chronic Sinus
0 Cirrhosis
0 Depression
0 Diabetes
0 Drug/Alcohol TX
0 Eating Disorder
0 Epilepsy/Seizures
0 Glaucoma
0 Heart Disease
0 Herpes
0 HIV / AIDS
0 Jaundice
0 Joint Replacement
0 Kidney Disease
0 Organ Transplant
0 Osteoporosis
0 Parkinson's
0 Radiation
0 Treatment
0 Severe Headaches
0 Sexually Transmitted Disease
0 Skin Problems
0 Tuberculosis
0 Ulcers

	Yes	No
Do you consider yourself currently under an *abnormally* high amount of stress?	o	o
Have you had an unexplained or unplanned weight loss recently?	o	o
When was your last complete physical exam with your physician, including blood tests? _____		
Do you now or have you ever smoked? If you currently smoke, how much? _____	o	o
If you were a smoker, when did you quit? _____		
Do you chew tobacco or use snuff? If yes, how often? _____	o	o

W O M E N O N L Y

	Yes	No
Are you currently pregnant? If yes, expected delivery date _____	o	o
Do you have regular gynecological checkups?	o	o
Have you reached menopause?	o	o
Are you on hormone replacement therapy?	o	o
Have you had a mammogram? Date _____	o	o

If you *currently* take these medications, check the box on the left. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

o Antibiotics	o
o Antidepressants (Prozac, Zoloft, etc.)	o
o Antihistamines	o
o Blood pressure medication	o
o Blood thinners	o
o Cortisone (Prednisone)	o
o Cholesterol medication	o
o Decongestants	o
o Diuretics (water pills)	o
o Hormones (birth control, estrogen)	o
o Inhalants	o
o Insulin	o
o Heart medication / nitroglycerine	o
o Muscle relaxants	o
o Pain medication (Aspirin, Advil, Tylenol)	o
o Sleeping pills	o
o Thyroid medication	o
o Tranquilizers	o
o Vitamins	o
o Others	o

_____

_____

	Yes	No
Do you drink alcohol? If yes, how much? _____	o	o
Do you drink sugary drinks/soda frequently	o	o
Do you chew gum?	o	o

Are you *ALLERGIC* to any of the following (get hives, a rash, have trouble breathing, etc.):

o Antibiotics (penicillin, tetracycline)
o Local dental anesthetics (novocaine)
o Codeine
o Aspirin
o Barbiturates or sedatives
o Tranquilizers
o Others

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	o	o
Do you have any disease, condition or medical problem not listed you feel we should know about?	o	o

_____

_____

_____

S I G N A T U R E S

Today's Date: _____

NOTES:

BP _____

PULSE _____

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Financial Policy

Thank you for choosing our office for your dental treatment. We are committed to offering a comprehensive approach to provide the highest quality of dental care. Please understand that payment of your bill is considered a part of your treatment.

- Please be aware that the patient / legal guardian is legally responsible for payment of all charges. We cannot send statements to other persons.
- Payment is expected in full for each appointment as services are rendered. For the convenience of our patients, we accept cash, personal checks, MasterCard, VISA, American Express or DISCOVER.
- *Cancellation Policy* - Please call at least 24 hours in advance if a cancellation is unavoidable so that we have an opportunity to appoint another patient.
- *Broken or missed appointments*- Broken or missed appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24-hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or apply a $40.00 broken appointment fee.
- *Dental Insurance* – There is no direct relationship between our office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services to render payment.
- Emergency Treatment – all emergency treatment must be paid in full at the time the service is rendered.
- Third Party patient financing may be available. Please contact someone at Issaqueena Prosthodontics to inquire about your specific requirements.

We recognize that under unusual circumstances an account balance may be incurred. Issaqueena Prosthodontics requires that all outstanding balances be paid in full within thirty (30) days unless other arrangements have been made. Please note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. We reserve the right to apply an interest rate of eighteen (18%) from the date of service. Thank you in advance for your understanding of our financial policy!

Signature _____ Date _____

Witness _____ Date _____

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare information about you may be used by Dr. Horton. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

"I acknowledge that I have received the full Privacy Notice."

Name (print)	Signature	Date
Witness	Signature	Date