CONFIDENTIAL PLEASE PRINT

PATIENT INFORMATION

Patient Name: _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #:_____ Birth Date:_____ Home Phone#:_____

Address:_____
No PO Boxes Street Apartment #_____

_____
City State Zip Code

Mailing Address :_____
If different above

Cell Phone:_____ E-Mail : _____

Responsible Party (for child or if other than above)

Name:_____ Relationship to Patient: _____

Social Security #:_____ Birth Date:_____

Address:_____
If different from above Street Apartment City State Zip Code

Employment Information

(if the patient is a child, please provide parent's employment information)

YOUR EMPLOYER

Employer Name:_____ Occupation:_____

Address:_____
Street City State Zip Code

Phone:_____ Ext:_____

SPOUSE'S EMPLOYER Spouse Name:_____

Employer Name:_____ Occupation:_____

Address:_____
Street City Zip Code

Phone:_____ Ext:_____

Dental Benefit Information (Primary Only) Required For Claim Submission

In order to submit a claim on your behalf, your insurance card is required. We will retain a copy for our records.

Insurance Plan Name:_____ Effective Date:_____ Group #:_____

Employee Name:_____ Date of Birth:_____ SSN or Alt. ID_____

Getting to Know You

Referred to us by ☐ Yellow Pages ☐Mail ☐ Insurance ☐ Website ☐ Location ☐ Patient/Other Name:_____

Is another family member or relative a patient at our office?:_____
Name Relationship

Person to Contact for Emergency:_____ Phone#:_____

Your former address:_____
Street

_____
City State Zip Code

Closest Relative (not living with you) _____ _____
Name Phone Number

_____
Street

_____
City State Zip Code

Consent for Services

To be signed by all patients

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Downing to make a thorough diagnosis of _____'s dental need.
  (name of patient)

- Upon diagnosis, I authorize 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 use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

- I understand that the fee estimates quoted for dental care can be extended for a period of six months from the date of the initial evaluation/diagnosis. Any unforeseen changes in treatment (at Doctor and/or patient discretion) may alter proposed treatment/fee fees and will be review as situations arise.

- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have made in advance. In the event payments are not received by agreed upon date, I understand that a 1-1½ % late charge (18% APR) my be added to my account. I will be responsible for any remaining balance, interest, late fees and court and/or attorney fees in the event of default.

- We try to remind patients prior to the appointment, but please do not depend on this courtesy. An appointment in this office is a contract of time reserved for you only. A missed or short notice cancellation leaves a serious void and reduces the effectiveness in caring for all patients. To avoid the broken appointment fee of $50 per ½ hour of scheduled time, at least 24-hour (business days) advance notice is required.

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

_____ Date:_____ Office Witness:_____
Signature of patient

_____ Relationship to Patient_____
Signature parent or responsible party (must be present)

Dental Benefits Authorization

I understand that all insurance quotes are **estimates only.** I agree to be solely responsible for ALL fees incurred regardless of insurance. In the event that insurance pays less than the estimated amount, I am responsible for the unpaid balance.

To the extent permitted under applicable law, I authorize release of any information relating to my dental claims. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Paul R. Downing, DMD, PC. A photo-copy of this document may act as an original.

_____ _____
Signature of patient Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed and/or received a copy of this office's Notice of Privacy Practices._____
Signature

I authorize the release of my protected health information to Spouse Parent (s) Other _____

_____ _____
Signature Date

We reserve the right to charge for appointments cancelled without 24-hour advance notice.

Patient Name

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name_____ Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No

Do your gums ever bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name_____Phone_____
   Address _____ City_____State_____ Zip_____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. **Are you taking any medication, drugs, pills or herbals now ?** ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A, B, C	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artifical Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/ Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
8. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above 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 any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Meds.

Allergies

Doctor Signature _____ Date _____