Patient Information Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Information

Legal Name: *Last* *First* *Middle Initial* Preferred Name: Title (Mr/Ms/Mrs etc.)

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other Date of Birth: Date of Previous Visit:

Email Address: Home Phone: *Include Area code* Work Phone: *Include Area code* Ext. Cell Phone: *Include Area code* Best time to call:

Address: *Mailing address* City: State: Zip:

Preferred appointment times:
Monday Tuesday Wednesday Thursday Friday Saturday Morning Afternoon Evening Any time

Whom may we thank for referring you to our practice?
Dental office Insurance company Friend School Internet Other

Name of person, office, or other source referring you to our practice:

Caregiver Information

Patient is an adult, needs caregiver Patient is an minor, I am their legal guardian Not Applicable

The following is for:
Patients who are unable to make medical decisions for themselves and have a caregiver to help assist in these decisions.

Name: *Last* *First* *Middle Initial* Preferred Name: Date of Birth:

Email Address: Home Phone: *Include area code* ( ) Work Phone: *Include area code* ( ) Ext. Cell Phone: *Include area code* ( ) Best time to call:

Address: *Mailing address* City: State: Zip:

Primary Insurance Information

I have dental insurance. I do not have dental insurance.

Primary Dental Insurance:

Name of the Member: *Last* *First* *Middle Initial* Date of Birth: Member ID #: Group #:

Member's Address: *Mailing address* City: State: Zip:

Member's Employers Name:

Employer's Address: *Mailing address* City: State: Zip:

Patient's relationship to insured member: ☐ Self ☐ Spouse ☐ Child ☐ Other Insurance Carrier Name: Insurance Plan Name/Number:

Secondary Insurance Information

I have secondary dental insurance. I do not have secondary dental insurance.

Secondary Dental Insurance:

Name of the Member: *Last* *First* *Middle Initial* Date of Birth: ID #: Group #:

Member's Address: *Mailing address* City: State: Zip:

Member's Employers Name:

Employer's Address: *Mailing address* City: State: Zip:

Patient's relationship to insured member: ☐ Self ☐ Spouse ☐ Child ☐ Other Insurance Carrier Name: Insurance Plan Name/Number:

By signing this page, I acknowledge that the insurance information I have given here is correct and up to date. To the best of my knowledge, I am currently eligible and an active member of the insurance group(s) listed above. I understand that if at any time my insurance is deemed inactive and/or ineligible to receive services, I will be charged the full usual and customary amount charged by Morning Dental for any services rendered to me after my inactive date.

Signature of patient or patient's representative Date:

Print Name Relationship to Patient (if not signed by the patient)

Office Policy Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Handle me with care

Put a checkmark in the box next to the statement that concerns or descibes you:

- ☐ I gag easily
- ☐ I feel out of control while I'm lying down in the dental chair
- ☐ I have not been to a dentist for a long time and I am worried about what you will tell me about my teeth and my dental hygiene
- ☐ I am embarrassed about the way my teeth look
- ☐ I have had a bad dental experience and have a lot of fear which has kept me from getting the dental care I need
- ☐ I am very apprehensive about the possibility of experiencing any pain. Therefore, pain relief is a top priority for me
- ☐ Please tell me what I need to know about my mouth so that I can make informed decisions
- ☐ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me
- ☐ I have difficulty listening and remembering when I am in the dental chair
- ☐ I would like to see pictures and videos that will help me understand my dental problems and their solutions
- ☐ I will need help with financing options so that I can spread my payments out over time
- ☐ Other

Appointment Policy

If you are late to your appointment...

Please be considerate and arrive on time for your scheduled appointment. Our staff tries our absolute best to accommodate your schedule. However, if you are 30 minutes or more late it may be necessary to reschedule your appointment in order to be courteous to all our other patients. In this possible occurrence, we will reschedule your appointment to a time which is convenient for our practice.

If you miss your appointment or fail to cancel within 24 hours of your appointed time...

At the First missed appointment without a 24 hour notice, a reminder will be issued. At the second missed appointment with out at 24 hour notice, **a penalty charge of $25.00** will be added to your account. At the third missed appointment without a 24 hour notice we will be compelled to dismiss the patient from our office due to patient uncooperatively for dental treatment. If it is needed to dismiss the patient from our office we will transfer dental records to the office of choice after all past due accounts are satisfied.

We will take into consideration emergencies such illness, accident, or personal problems which may prevent your attendance to your scheduled appointment. Please be courteous enough to notify our office as soon as possible If you have any questions regarding these policies, please do not hesitate to ask. We are committed to provide you with the utmost experience in dental care.

Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Morning Dental's Notice of Privacy Practices, which has an effective date of 10/01/16, and which describes how my health information may be used and disclosed.

I understand that Morning Dental has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact Morning Dental at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of patient or patient's representative Date:

Print Name Relationship to Patient (if not signed by the patient)

Name of family member or representative that Morning Dental can release information to

Financial Policy

Regarding Dental Insurance Claims...

I acknowledge that dental insurance is a contract between the patient or employer with the insurance company, **not with the dental office.** Morning Dental has no control over payments or reimbursement by the insurance company. I understand that Morning Dental will make every effort possible to assist me with my particular coverage. Although it is not required, Morning Dental will prepare and submit my insurance claim at no cost as a courtesy to me.

I understand that I can ask my insurance company for a copy of all procedures and its associated copay fees that are covered by my insurance plan. I understand that Morning Dental will also provide an "**ESTIMATE**" of cost that is due at the time of treatment. Should the "**ESTIMATE**" be too high, a refund will be issued to me. Likewise, if the "**ESTIMATE**" is lower than the actual cost, it is my responsibility to pay the difference. Should no insurance payment be made within ninety days of a submitted claim, the fee will become my sole responsibility.

I also understand that if it is determined that I was ineligible for insurance coverage at the time of services, I will pay Morning Dental the full usual and customary fees for the procedure services rendered to me.

Signature of patient or patient's representative Date:

Print Name Relationship to Patient (if not signed by the patient)

Health History Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle* | Home Phone: *Include area code* ( ) | Cell Phone: *Include area code* ( )

Address: *Mailing address* | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of Birth: | Sex: M F

Social Security #: | Emergency Contact: | Relationship: | Contact's Home Phone: ( ) | Contact's Cell Phone: ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.			
Are you currently under the care of a physician due to a specific condition	☐	☐	☐

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: Date of last dental x-rays:

What was done at that time:

How frequently do you brush your teeth:

How frequently do you floss your teeth:

When was your last visit to the dentist?

Are any of your teeth loose, or are you concerned about any teeth loosening?:

Prior Dentist's name, address, & phone number?

What is the reason for your dental visit today?

How do you feel about your smile?

If you could change anything about your mouth, teeth, or smile, what would it be:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	**No**	**DK**
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	**No**	**DK**
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) — Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: ____________ If yes, have you had any complications? ________________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: ______________________________

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ________________
If yes, how much do you typically drink i n a week? ________________

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____	☐	☐	☐
Aspirin ____	☐	☐	☐
Penicillin or other antibiotics ____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____	☐	☐	☐
Sulfa drugs ____	☐	☐	☐
Codeine or other narcotics ____	☐	☐	☐
Metals ____	☐	☐	☐
Latex (rubber) ____	☐	☐	☐
Iodine ____	☐	☐	☐
Hay fever/seasonal ____	☐	☐	☐
Animals ____	☐	☐	☐
Food ____	☐	☐	☐
Other ____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion (If yes, date: ____)	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders (If yes, specify: ____)	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders (Specify: ____)	☐	☐	☐
Recurrent Infections (Type of infection: ____)	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: — Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient or patient's representative — Date:

Signature of Dentist: — Date:

FOR COMPLETION BY DENTIST

Comments: ________________________________

Informed Consent for Simple Cleaning

By reading and signing this document, I consent to have Morning Dental's doctors and staff perform the following procedures to me: **simple cleanings**.

BENEFITS: I understand that some of the benefits from this procedure could be:

- Looks better
- Cleans mouth
- Eliminates odors
- Prevents odors
- Prevents aggravation of gum disease
- Some parts may be performed by auxillary personnel

POSSIBLE COMPLICATIONS: I understand that some of the possible complications from this procedure could be:

- Sensitive teeth
- Tender/bleeding gums
- Feeling spaces between teeth
- The filling can be loosened (normal if filling was about to fall out).

CONSEQUENCES OF NOT DOING THIS PROCEDURE OR POSTPONING: I understand that some of the possible consequences of not doing this procedure or postponing it are:

- Stained teeth
- Gum disease
- Scents
- Loss of teeth / supporting bone
- Systematic spreading of bacteria from plaque and calculus

ALTERNATIVES: Alternative treatments to getting cleanings are:

- None

I also understand that this procedure may require the doctor or staff at Morning Dental to take **additional x-rays**. I understand that these x-rays will be used to help the doctor or staff better understand my dental needs while performing this procedure. (Please inform the staff if you think there is a chance you may be pregnant).

BENEFITS: I understand that some of the benefits from this procedure could be:

- More complete diagnosis

POSSIBLE COMPLICATIONS: I understand that some of the possible complications from this procedure could be:

- Exposure to x-ray radiation (minimum)

I also understand that this procedure may require the doctor or staff at Morning Dental to use **local anesthesia**.
(Please inform the staff if you think you think you have had any allergic reactions with dental anesthetics in the past).

BENEFITS: I understand that some of the benefits from this procedure could be:

- Avoiding pain during treatment & procedures

POSSIBLE COMPLICATIONS: I understand that some of the possible complications from this procedure could be:

- Prolonged numbness (which can extend beyond normal)
- Bruising (hemotoma)
- Nerve damage
- Fillings may fall out
- May include those applicable to general anesthesia including but not exclusive to allergic reactions up to and including death. (RARE)

I have read the above and have received a copy of them if requested, and recognize their importance in helping me with my decisions. My signature indicates that I have read and understood this consent document. I recognize that failures can occur for all kinds of reasons and that complications can occur in any procedure. I also understand that, where decay has occurred, or a tooth has fractured or abscessed, these same forces are still working on the tooth even after it has been restored; therefore, decay or a fracture can still occur as the restored tooth is no better than what nature has given in the first place. If for any reason a conflict or disagreement should arise I will first present such conflict or disagreement to my attending dentist in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation/mediation board such as the dental society and agree to accept their solution in lieu of pursuing remedies by way of litigation. I also understand that this agreement is binding on my heirs and all other family members. I now give my consent to the attending dentist to render to me the dental treatment that we have agreed is necessary for myself. I also agree to reimburse the attending dentist for all services rendered to me and I am aware that the payment is due when services are rendered.

DATE:_______________ ________________________________ **Signature of Patient / Guardian**

CHART #:_____________ ________________________________ **Patient's Name**

________________________________ **DOCTOR'S SIGNATURE**