Patient Information

Patient Name: ____________________ DOB: ____________ SSN: ______________

Address: ____________________ City: __________ State: ________ Zip: ________

Email: ________________ Cell Phone: ______________ Home Phone: ______________

Emergency contact: ________________ Phone: ______________ Relationship: ______________

Pharmacy: ________________ Phone: ____________ Address: ________________________

How did you hear about us? ☐ Mail ☐ Flyer ☐ Facebook ☐ Instagram ☐ Google ☐ Yelp

Dental History

- ☐ Pain in mouth
- ☐ Sensitivity (hot, cold, sweets, pressure)
- ☐ Discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Jaw/joint pain
- ☐ Teeth or fillings breaking
- ☐ Repair chipped teeth
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose teeth
- ☐ Teeth shifting
- ☐ Bad breath or bad taste in your mouth

When was your last dental visit? ________________

Have you ever had:

- ☐ Braces
- ☐ Periodontal/Gum disease
- ☐ CPAP machine
- ☐ Dentures
- ☐ Partial Dentures

Are you interested in the following:

- ☐ Closing spaces
- ☐ Replace old crowns
- ☐ Whitening
- ☐ Straightening teeth
- ☐ Sedation dentistry (nitrous, oral)
- ☐ Botox/Filler
- ☐ Replace silver fillings
- ☐ Replace missing teeth

Allergies:

Do you have any allergies?

- ☐ No
- ☐ Penicillian
- ☐ Clindamycin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Costume Jewelry
- ☐ Other:

Medical History

- ☐ AIDS/HIV postitive
- ☐ Anemia
- ☐ Arthritis
- ☐ Articial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer Type? ________
- ☐ Chemotherapy Dates
- ☐ Diabetes Type 1 Type 2
- ☐ Other: ________________
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/Valve prolapse
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant Due Date?
- ☐ Radiation Treatment
- ☐ Ulcers
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stent
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco User
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Veneral Disease

☐ Medications: ________________

☐ Past surgical history: ________________

Are you taking osteoporosis medications?

- ☐ Yes ________________
- ☐ No

Primary Care Physician: ________________

Phone: ________________

Quality Assurance:

We take pride in ensuring our patients are cared for efficiently. Our providers recommend individualized treatment based on the standard of care. We guarantee the services that we provide and encourage our patients to inform us if they are ever dissatisfied with a service they received.
Please note that our quality assurances could be null and void if your re-care appointments are not maintained. The key to maintaing your oral health is to keep your scheduled hygiene visits, x-rays and recommended fluoride treatments. Home care includes brushing, flossing and use of any prescribed oral health products.
Failure to have scheduled re-care visits every six months minimum with our office will void all warranties.
Please note: accidents or trauma that could cause damage to teeth or dental prosthesis would not be covered under our quality assurance.

Cancellation Policy:

Our goal is to provide quality dental care in a timely manner, although we understand that emergencies can come up. If you are unable top keep your scheduled appointment, please give a 24 hour notice to avoid same day cancellation or missed appointment fees.
If less than 24 hours notice is given, you will be expected to pay $57 cancellation fee.
Please note that confirming your appointment is very important to us. Please confirm your appointment 24 hours before the scheduled appointment time. Failure to do so will result in the appointment being cancelled and replaced with another patient that is waiting for an appointment
If three appointments have been missed in one year, the patient will be dismissed from the practice.
Late to appointments: If you are more than 10 minutes late, we may or may not have time for scheduled treatment it will be of discretion at time of arrival.
Thank you for understanding the importance of our provider's time.

Financial Agreenment:

For your convenience you can pay for your treatment with cash, check, credit card, or through a third-party financing who partners with us to ensure all patients receive the care they need. We will collect the payment of your treatment at the time of service.
If you would like to use your dental insurance, we will gladly file the insurance claims on your behalf for the portion you expect your insurance to pay. We will also post to your account any insurance payment and adjustments we may receive. We will let you know if your insurance covers only part of the claim and that you may send us the payment for the balance. If you have the need to change any financial arrangements for any reason, please let us know that we may work with you.
In the event any portion of balance remains unpaid longer than 30 days we will initiate a collection process, which may include collection and financing fees.

Agreement:
By signing below, I confirm that I understand this financial process, and agree with every step. I also state that I am responsible for the cost of my treatment and any third-party financing or insurance carrier unpaid balance. I understand and agree that this dental office shares my personal health information for collection purposes only. This agreement does not authorize the dental office to share my information for any other purpose. I understand the dental office may initiate a collection process if any cost for my treatment remains unpaid longer than 30 days.

Treatment Consent - Adult:

I give my consent to receive dental treatment, education, and other dental-related services. I authorize the administration of anesthetics, as may be considered necessary, and to the use of oral x-rays during the treatment. I will receive instructions about the benefits and risks of the necessary procedures, and I will have the opportunity to discuss and approve the recommended treatment. I acknowledge that I have not received guarantees, warranties, or representations concerning the results of the treatment or procedures.

I accept the responsibility to follow oral hygiene and post-op instructions, come to all the appointments on the proper day and time, provide accurate and updated health information, and alert this office of anything that may adversely affect the treatment.

I have the right to withdraw this consent at any time. I will still be responsible for the unpaid balance and for any complication arising from the treatment interruption.

Summary of Notice of Pricacy Practices:

Park Hills Dentistry keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. Law requires us, and by our code of ethics, to keep your information private, and to follow the practices out Lined in this Notice.
I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission

Patient /GuardianSignature:____ Date:____________