Patient Information

Patient Name:_____ _____ _____ I *prefer* you call me: _____
First Middle Last

Male: ❑ Female: ❑ Single: ❑ Married: ❑ Divorced: ❑ Widowed: ❑ Other: ❑ _____

Phone-Home: (___)_____Cell: (___)_____Work: (___)_____ Ext: _____

My preferred Contact phone number is: Home: ❑ Cell: ❑ Work: ❑ Birthdate: ___/___/___ Age:_____

Street Address:_____Apartment#_____

City_____ State_____ Zip Code: _____ SS#:_____

Occupation: _____Employer & Address:_____

May we leave a message with detailed information at the following #'s: Home: ❑ Cell: ❑ Work: ❑

May we communicate when necessary with you via email? Y/N email address:_____

Whom may we contact in case of emergency?_____ Relationship: _____

Emergency contact H: _____ Cell: _____ Wk: _____ Ext: _____

Whom may we thank for referring you to our practice?_____& please check their corresponding box: Referring Dentist: ❑ Another patient, friend or relative: ❑ Website/search: ❑ Yellow Pages: ❑

Spouse Information

Spouse's Name:_____ _____ _____ Birthdate: ___/___/___
First Middle Last

Phone- Cell: (____)_____Work: (____)_____ Ext: _____

Employer: _____ Occupation: _____

Responsible Party

Who will be responsible for your account? Self: ❑ (**if self, skip to next section**)Spouse: ❑ Parent: ❑ Other: ❑

Responsible Party Name:_____ _____ _____ Birthdate: ___/___/___
First Middle Last

Billing Address:_____Apartment#_____

City_____State_____Zip Code: _____ SS#:_____

Phone-Home: (___)_____Cell: (___)_____Work: (___)_____ Ext: _____

Employer: _____ Occupation: _____

❑ I do not have any dental insurance coverage-Skip to PAGE 3

For those patients having dental insurance please complete *all* the information below.
As a courtesy to you, we will file your claims to your insurance company electronically whenever possible. Electronic filing assists in a shorter turnaround of insurance benefits. Please remember that most insurance plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any portion your plan does not cover.
We encourage you to become familiar with your insurance plan-policy exclusions, deductibles. It is your responsibility to understand your plan(s) benefits. Each company varies according to the contract elected by the employer. **Please be aware that we are not participating providers with any specific dental plan.**

Primary Dental Insurance Company

Name of Policy Holder:_____ _____ _____ Birthdate: ___/___/___
First Middle Last
Relation to Policy Holder: Self: ❑ Spouse: ❑ Child: ❑ Other: ❑ _____
Insurance Company:_____ Insurance Company Address: _____
City: _____State_____Zip Code: _____ Insurance Phone:( )_____
Policy Holder ID Number: _____ Group #: _____
Do you have additional dental insurance? Yes: ❑ No: ❑ If yes, complete the following box below:

Secondary Dental Insurance Company

Name of Policy Holder:_____ _____ _____ Birthdate: ___/___/___
First Middle Last
Relation to Policy Holder: Self: ❑ Spouse: ❑ Child: ❑ Other: ❑ _____
Insurance Company:_____ Insurance Company Address: _____
City: _____State_____Zip Code: _____ Insurance Phone:( )_____
Policy Holder ID Number: _____ Group #: _____

Authorization & Release

To assist us in obtaining your benefits, please sign the "Assignment of Benefits" below to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Prosthodontic Associates to release to my insurance company, information acquired in the course of dental care to assist in the processing of claim(s) for the insured having coverage through my plan policy. This signature on file is my authorization for the release of information necessary to process my claim(s) and release information to other health care providers regarding my history, examination and treatment course. I also authorize benefits to be paid directly to the doctor (except for those plans that pay the patient directly when seeing a non-participating doctor). I understand that I am responsible for any unpaid balance on my account. It is my responsibility to inform this office of any changes to my records, medical status and insurance coverage.

_____ _____
Signature of patient/policy holder Date

MEDICAL & DENTAL QUESTIONNAIRE

Mark your response to indicate if you have had any of the following diseases or problems. If you are unsure then mark don't know (**DK**). Please use the space provided to further explain any medical conditions.

Are you in good health? **Y/N** --- Currently under the care of a physician? **Y/N** Date of last visit:_____
Name/Location of physician:_____ Phone#:_____ Treated for:_____
Have there been any changes in your general health over the past year? **Y/N** (if yes)_____
Do you or have you taken ***any*** of the following: Phen-Fen: ❑ Redux: ❑ Oral bone density medications containing bisphosphonates (such as Fosamax, Actonel or Boniva): ❑ Intravenous bisphosphonates (such as Reclast, Zometa, Aredia or Bonefos): ❑ No to all: ❑

Yes	No	DK	Cardiovascular
❑	❑	❑	High blood pressure
❑	❑	❑	Low blood pressure
❑	❑	❑	Swollen feet/ankles
❑	❑	❑	Rheumatic fever
❑	❑	❑	Angina (chest pain)
❑	❑	❑	Heart attack
❑	❑	❑	Irregular heart beat
❑	❑	❑	Heart surgery
❑	❑	❑	Congestive heart failure
❑	❑	❑	Damaged heart valve
❑	❑	❑	Bacterial endocarditis (heart infection)
❑	❑	❑	High cholesterol
❑	❑	❑	Heart infection
❑	❑	❑	Cardiac pacemaker
❑	❑	❑	Heart transplant
❑	❑	❑	Heart murmur
❑	❑	❑	Mitral valve prolapse
❑	❑	❑	Prosthetic (artificial) heart valve
❑	❑	❑	Vascular graft
❑	❑	❑	Vascular stent
❑	❑	❑	Aneurysm
❑	❑	❑	Congenital heart defect

Yes	No	DK	Hematologic
❑	❑	❑	Anemia
❑	❑	❑	Sickle cell anemia
❑	❑	❑	Hemophilia
❑	❑	❑	Leukemia
❑	❑	❑	Blood transfusion
❑	❑	❑	Bruise easily
❑	❑	❑	Abnormal or Excessive bleeding

Yes	No	DK	Respiratory
❑	❑	❑	Asthma
❑	❑	❑	COPD ___Emphysema ___Chronic Bronchitis
❑	❑	❑	Chronic cough
❑	❑	❑	Lung Disease
❑	❑	❑	Tuberculosis
❑	❑	❑	Difficulty Breathing
❑	❑	❑	Shortness of breath
❑	❑	❑	Sinus congestion
❑	❑	❑	Sinus infections
❑	❑	❑	Sleep Apnea
❑	❑	❑	Snoring
❑	❑	❑	Other sleep disorder _____

Yes	No	DK	Endocrine
❑	❑	❑	Diabetes Type_____
❑	❑	❑	Hypoglycemic (low blood sugar)
❑	❑	❑	Thyroid disease

Yes	No	DK	Skin
❑	❑	❑	Hives
❑	❑	❑	Skin rash
❑	❑	❑	Other skin lesions _____

Yes	No	DK	Immune
❑	❑	❑	Swollen lymph glands
❑	❑	❑	Immunosuppressed
❑	❑	❑	Sjogrens's Syndrome
❑	❑	❑	Past steroid usage
❑	❑	❑	Delayed healing

Yes	No	DK	Gastrointestinal
❑	❑	❑	Acid reflux/GERD
❑	❑	❑	Irritable Bowel Syndrome
❑	❑	❑	Stomach Ulcer
❑	❑	❑	Stomach or Intestinal disease _____
❑	❑	❑	Gallbladder trouble

Yes	No	DK	Musculoskeletal
❑	❑	❑	Arthritis Osteo_____ Rheumatoid_____
❑	❑	❑	Artificial joint (s) Type_____ Date of placement: _____
❑	❑	❑	Pre-medication required by physician for joint replacement? Yes___ No___
❑	❑	❑	Fibromyalgia
❑	❑	❑	Lupus
❑	❑	❑	Back problems
❑	❑	❑	Osteopenia
❑	❑	❑	Osteoporosis
❑	❑	❑	Osteonecrosis

Yes	No	DK	Hepatic
❑	❑	❑	Liver Disease-Cirrhosis
❑	❑	❑	Jaundice
❑	❑	❑	Hepatitis Type_____

Yes	No	DK	Neurologic
❑	❑	❑	Epilepsy
❑	❑	❑	Parkinson's Disease
❑	❑	❑	Multiple Sclerosis
❑	❑	❑	Frequent Headaches
❑	❑	❑	Migraines
❑	❑	❑	Fainting
❑	❑	❑	Seizures Due to injury? _____
❑	❑	❑	Dizzy spells
❑	❑	❑	Convulsions
❑	❑	❑	Traumatic brain injury (concussion)
❑	❑	❑	TIA (transient ischemia attack)
❑	❑	❑	Aneurysm
❑	❑	❑	Stroke

Yes	No	DK	Allergies
❑	❑	❑	Local anesthetic _____
❑	❑	❑	Hay fever
❑	❑	❑	Antibiotics
			Penicillin ❑
			Sulfa ❑
			Other ❑ _____
❑	❑	❑	Anaphylactic incident
❑	❑	❑	Aspirin/ibuprofen
❑	❑	❑	Acetaminophen (Tylenol)
❑	❑	❑	Codeine
❑	❑	❑	Other narcotics _____
❑	❑	❑	Metals
❑	❑	❑	Latex
❑	❑	❑	Scanning dye

Other:_____

Yes	No	DK	Renal
❑	❑	❑	Kidney disease
❑	❑	❑	Dialysis
			Schedule being maintained_____

Yes	No	DK	Infections
❑	❑	❑	HIV positive
❑	❑	❑	AIDS
❑	❑	❑	Sexually transmitted diseases

Yes	No	DK	Eyes/Ears/Head
❑	❑	❑	Glaucoma
❑	❑	❑	Impaired vision
❑	❑	❑	Impaired hearing

Yes	No	DK	Mental Health
❑	❑	❑	Anxiety
❑	❑	❑	Depression
❑	❑	❑	Schizophrenia
❑	❑	❑	Bipolar disorder
❑	❑	❑	Eating disorder
❑	❑	❑	Learning disorder
❑	❑	❑	Dementia
❑	❑	❑	Alzheimer's

Other_____

Yes	No	DK	Other
❑	❑	❑	Tumor or growth
❑	❑	❑	Cancer-Type_____
❑	❑	❑	Radiation Treatment
❑	❑	❑	Chemotherapy Treatment
❑	❑	❑	Chronic fatigue
❑	❑	❑	(Women) Pregnant Y/N-Nursing Y/N
❑	❑	❑	Chemical dependency
❑	❑	❑	Alcohol abuse
❑	❑	❑	Tobacco use:
			cigarettes:___ E-products:___
			smokeless tobacco:___ cigars:___
❑	❑	❑	Illicit drug use

Please list any disease, condition, or problem you have that is not listed above or elaborate on any of the checked boxes if necessary.

_____

_____

_____

❑ I do not take any medications. Skip to page 5.

Please list any prescription and/or over the counter medications that you are taking including vitamins or herbal supplements.

Medication	*Dosage*	*Frequency*	*Condition/Reason for taking*

DENTAL INFORMATION

What is the reason for your dental visit today?_____
My current dental health is? Good: ❑ Fair: ❑ Poor: ❑
How often do you brush your teeth? ____/day how & often do you floss?_____
Who is your ❑ previous dentist ❑ present dentist: _____
When was your last dental visit:_____

Yes No

- ❑ ❑ Is it important for you to keep your teeth?
- ❑ ❑ Are you satisfied with the appearance of your teeth?
- ❑ ❑ Are you satisfied with the function of your teeth?
- ❑ ❑ Does food frequently get caught between teeth?
- ❑ ❑ Do your gums often bleed while brushing?
- ❑ ❑ Have you noticed loosening of your teeth?
- ❑ ❑ Have you injured your head, neck, or jaw?
- ❑ ❑ Do you have difficulty eating or swallowing?
- ❑ ❑ Do you have a dry mouth?

Yes No

- ❑ ❑ Have you noticed clicking of the jaw?
- ❑ ❑ Do you have pain in joint, ear side of face? (circle any that apply)
- ❑ ❑ Do you have difficulty opening or closing your jaw?
- ❑ ❑ Do you have difficulty chewing?
- ❑ ❑ Do you clench or grind your teeth?
- ❑ ❑ Do you bite your lips or cheek frequently?

Yes No Have you had:

- ❑ ❑ Orthodontic treatment (braces)?
- ❑ ❑ Oral surgery?
- ❑ ❑ Perio surgery (gum surgery)?
- ❑ ❑ Your bite adjusted?
- ❑ ❑ A bite plane/guard or other appliance?
- ❑ ❑ A change in your ability to taste foods?

Yes No Do you currently have:

- ❑ ❑ Dental Pain?
- ❑ ❑ Sores or swelling in your mouth?
- ❑ ❑ Bad breath?
- ❑ ❑ Broken fillings?
- ❑ ❑ Sensitivity to ❑ Cold ❑ Hot ❑ Sweets ❑ Biting down?
- ❑ ❑ Do you supplement your diet with fluoride?
- ❑ ❑ A partial denture?
- ❑ ❑ A full denture?
- ❑ ❑ Dental implants?
- ❑ ❑ Have you had any difficulty with dental treatment? Please explain:_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold Prosthodontic Associates dentists or staff members responsible for any errors or omissions that I may have made in the completion of this form. This signature authorizes the release of information to other health care providers regarding my history, examination and treatment course when applicable. It is *my* responsibility to inform this office of any changes to my records, medical status and/or insurance coverage. I acknowledge I am ultimately financially responsible for my balance & understand the methods of payment are Visa, Master Card, Discover, American Express, cash and personal checks. We also offer Care Credit as an option for your care.

_____ _____

Patient Signature Date

PLEASE PROCEED TO PAGE 6

PROSTHODONTIC ASSOCIATES

Consent for use and disclosure of health information (HIPAA)

Section A: Patient Giving Consent
Name:_____
Address:_____
Telephone:_____ E-mail:_____

Section B: To the Patient-Please Read the Following Statements Carefully

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of you protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent upon request. We encourage you to read it carefully and completely before signing this.

We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will containing the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Diane Cunningham, Practice Manager 651-633-4914 or manager@pros-specialists.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____am aware of Prosthodontic Associates' Notice of Privacy Practices
Print Name (a copy is available upon request and is posted is available in the reception area)

Request for Family member to have access to protected health information

The name(s) listed below are family member(s), friend and/or personal representative to whom I wish to grant access to my healthcare information. I hereby authorize Prosthodontic Associates to disclose my Protected Health Information (PHI) including appointment and billing information to the following:

	Name	Relationship to Patient
1.	_____	_____
2.	_____	_____

❑ None

I understand this consent will be considered valid until such time I revoke it. I may revoke this authorization by sending a written request for revocation to Prosthodontic Associates. I understand the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I have read each section above and agree to these terms.

_____ _____
Patient /Personal Representative Signature Date

If this consent is signed by a personal representative on behalf of the patient complete the following:

_____ _____
Personal Representative's name Relationship to patient