i-ImplantDentistry
innovative · informative · individual
Specialists in Implant, Esthetic & Restorative Dentistry

New Patient Information

Patient Name: _____ _____ _____
(First) (Middle) (Last)

Male ☐ Female ☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Other: ☐

Date of Birth: _____/_____/_____ Age: _____

Phone: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Preferred Contact Method: Home ☐ Cell ☐ Work ☐ May we leave a detailed message: Y / N

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____Occupation: _____

Employer & Address:

_____

Email: _____ How did you hear about our office: _____

General Dentist: _____ Contact Info: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship to you:_____

Phone: Cell: _____ Alternative Phone _____

Responsible Party

Who is Responsible for your Account: Self: ☐ Parent: ☐ Other: ☐
_____ (If Self Skip to Next Section)

Responsible Party Name: _____ DOB: ____/____/_____

Billing Address:

_____

Phone: _____ Email: _____

Photo Release

I authorize i-Implant Dentistry to use my dental photographs for the purpose of clinical teaching, patient education and marketing. I understand that my photos will be used at my dentist's discretion in the office, on the i-Implant Dentistry website, and/or in their marketing materials.

Patient Signature:_____Date:_____

☐ *I do not consent to my images being used.*

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.

Date of your last physical _____

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
☐	☐	☐	Emphysema
☐	☐	☐	Chronic Bronchitis
☐	☐	☐	Chronic cough
☐	☐	☐	Lung disease
☐	☐	☐	Tuberculosis
☐	☐	☐	Difficulty breathing
☐	☐	☐	Shortness of breath
☐	☐	☐	Sinus congestion
☐	☐	☐	Sinus infections
☐	☐	☐	Sleep Apnea
☐	☐	☐	Snoring

Other Sleep Disorders?_____

YES	NO	DK	**ENDOCRINE**
☐	☐	☐	Diabetes Type 1 ☐ Type 2 ☐

Last A1C Value: _____

Date of last A1C? _____

If Diabetic, do you test daily? ☐ Yes ☐ No

How Often? _____

☐	☐	☐	Hypoglycemic (low blood sugar)
☐	☐	☐	Thyroid disease

YES	NO	DK	**SKIN**
☐	☐	☐	Hives
☐	☐	☐	Skin rash
☐	☐	☐	Other skin lesions

_____

YES	NO	DK	**IMMUNE SYSTEM**
☐	☐	☐	Swollen lymph glands
☐	☐	☐	Immunosuppressed
☐	☐	☐	Sjogren'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 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
☐	☐	☐	Anaphylactic incident
☐	☐	☐	Local anesthetic
☐	☐	☐	Hay Fever
☐	☐	☐	Penicillin ☐ Sulfa ☐
☐	☐	☐	Aspirin/Ibuprofen
☐	☐	☐	Acetaminophen (Tylenol)
☐	☐	☐	Codeine

Other Med Allergies ?_____

☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Scanning dye

Other Allergies?

_____

YES	NO	DK	RENAL
☐	☐	☐	Kidney disease
☐	☐	☐	Dialysis Schedule maintained

YES	NO	DK	INFECTIONS
☐	☐	☐	HIV positive
☐	☐	☐	AIDS
☐	☐	☐	Sexually transmitted disease(s)

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	WOMEN
☐	☐	☐	Pregnant
☐	☐	☐	Nursing

YES	NO	DK	OTHER
☐	☐	☐	Tumor or Growth
☐	☐	☐	Cancer Type: _____
☐	☐	☐	Radiation Treatment
☐	☐	☐	Chemotherapy Treatment
☐	☐	☐	Chronic Fatigue

YES	NO	DK	ADDICTION
☐	☐	☐	Alcohol Abuse
☐	☐	☐	Chemical Dependency
☐	☐	☐	Tobacco Use

Cigarettes ☐ E-Products: ☐ Cigars: ☐

Smokeless tobacco: ☐

How many per day ? Min: _____ and Max: _____

How long have you been using tobacco?_____

☐	☐	☐	Illicit Drug Use

YES	NO	DK	SEDATION/GENERAL ANESTHESIA
☐	☐	☐	Previous history of issues
☐	☐	☐	Personal Complications
☐	☐	☐	Family History of Complications

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

_____

_____

_____

Medications, Vitamins and Supplements

☐ I DO NOT TAKE ANY MEDICATIONS

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

*The above information is accurate and complete to the best of my knowledge. I will not hold i-Implant Dentistry 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 and understand the methods of payment are Visa, Master Card, Discover, American Express, cash and personal checks. We also offer Care Credit, Proceed, Lending Club and Cherry healthcare financing as an option for funding your dental care.*

Patient Signature: _____ *Date:*_____

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Consent For Use And Disclosure Of Health Information (HIPAA)

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 signing this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your 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 contain 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 our office. (651)505-3000 or (320) 331-3000.

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 ***i-Implant Dentistry.*** Please understand that revocation of this consent will NOT affect any action we took in reliance of 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 i-Implant Dentistry's Notice of Privacy Practices.
Print Name **(a copy is available upon request)**

Request for Family Members to have access to protected health information

The names listed below are family members, friends, and/or personal representatives to whom I wish to grant access to my healthcare information. I hereby authorize i-Implant Dentistry to disclose my Protected Health Information (PHI) including appointments and billing information to the following:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

☐ **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 i-Implant Dentistry. 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 and understand the above information 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: _____
(Print Name)