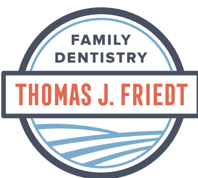

PATIENT INFORMATION

Full Name ______________________ Preferred Name ______________________

Address ______________________ Apt # ______________________

City ______________________ State/Zip ______________________

Birthdate ______________________ Email ______________________

Home Phone ______________________ Social Security # ______________________

Cell Phone ______________________ ☐ Male ☐ Female

Business Phone ______________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Employer ______________________ Occupation ______________________

Family members who are current patients ______________________

Will you be added to their account? Yes / No

PRIMARY INSURANCE INFORMATION – SUBSCRIBER INFORMATION

Name ______________________ Birthdate ______________________

Address ______________________ Apt # ______________________

City ______________________ State/Zip ______________________

Home Phone ______________________ Employer ______________________

Cell Phone ______________________ Occupation ______________________

Work Phone ______________________ Ins. Phone ______________________

Insurance Co. ______________________ Group # ______________________

Insurance ID # ______________________ Social Security # ______________________

SECONDARY INSURANCE INFORMATION – SUBSCRIBER INFORMATION

Name ______________________ Birthdate ______________________

Address ______________________ Apt # ______________________

City ______________________ State/Zip ______________________

Home Phone ______________________ Employer ______________________

Cell Phone ______________________ Occupation ______________________

Work Phone ______________________ Ins. Phone ______________________

Insurance Co. ______________________ Group # ______________________

Insurance ID # ______________________ Social Security # ______________________

EMERGENCY CONTACT

Name ______________________ Relation ______________________

Home Phone ______________________ Cell Phone ______________________

Name of Family Physician ______________________

Office Phone ______________________

How did you hear about our office? ______________________

PATIENT'S FULL NAME______________________________ **DATE OF BIRTH** __________

Home Address ____

Home Phone__________________ **Mobile**__________________ **Office** ______________

Email (for access to our online patient portal) ________________________________

Are you allergic to anything?............................Yes No

If YES – please specify:

- ☐ Penicillin ☐ Aspirin
- ☐ Codeine ☐ Novacaine
- ☐ Mycin Drugs ☐ Xylocaine
- ☐ Sulfa ☐ Latex
- ☐ Other ______________________

Do you have/had any of the following?

- Abnormal Bleeding/Hemophilia........................Yes No
- Acid Reflux/GERD...Yes No
- AIDS/HIV Infection ....Yes No
- Anemia/Sickle Cell Anemia ....Yes No
- Arthritis ....Yes No
- Asthma ....Yes No
- Autoimmune Disorder......................................Yes No
- Cancer...Yes No
- Cardiovascular Disease ....Yes No

If YES – please specify:

- ☐ Angina ☐ Heart Attack
- ☐ Arteriosclerosis ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve ☐ High Blood Pressure
- ☐ Congenital Heart Defect ☐ Low Blood Pressure
- ☐ Congestive Heart Failure ☐ Pacemaker
- ☐ Coronary Artery Disease ☐ Heart Murmur
- ☐ Damaged Heart Valve ☐ Rheumatic Fever
- ☐ Other______________________

- Cold Sores/Fever Blisters.................................... Yes No
- Diabetes .... Yes No
- Dizziness/Fainting .... Yes No
- Eating Disorder.. Yes No
- Epilepsy/Seizures.. Yes No
- Frequent Headaches.. Yes No
- Hepatitis/Liver Problems .... Yes No
- Joint Replacement... Yes No
- Kidney Problems .... Yes No
- Mental/Emotional Disorder................................. Yes No
- Neurological Problems .... Yes No
- Organ Transplant .... Yes No
- Osteoporosis .... Yes No
- Radiation Treatment/Chemotherapy .... Yes No
- Respiratory Disease/COPD................................ Yes No
- Stroke .... Yes No
- Thyroid Problems .... Yes No
- Tuberculosis.. Yes No

Are you taking prescription medications?...... Yes No

If YES, please list______________________

____

____

Are you taking over-the-counter medications?Yes No

If YES, please list______________________

____

Are you taking any herbal supplements? .... Yes No

If YES, please list______________________

____

Are you pregnant?... Yes No

If YES, what month?___________________

Have you had ANY surgeries? .... Yes No

If YES, please specify__________________

____

____

When was your last physical examination?_________

Are you now under the care of a physician? .. Yes No

If YES, why?_________________________

Do you currently use tobacco of any type?.... Yes No

If YES, which type?_____________________

If YES, how long have you used tobacco?_______

Are you a former tobacco user? .... Yes No

If YES, which type?_____________________

If YES, how long have you used tobacco?_______

- **History of alcohol or drug dependency?** ....Yes No
- **Do you have dry mouth issues?** ....Yes No
- **Have you ever had any jaw problems?** ....Yes No
- **Does your jaw ever pop or click?** ....Yes No
- **Do you have pain or tenderness in your jaw?** ..Yes No
- **Has your jaw ever locked open or closed?**.......Yes No
- **Do you clench or grind your teeth?**...................Yes No
- **Have you had trauma to your chin or jaw?** ....Yes No
- **History of periodontal disease?**..........................Yes No

If YES, have you had treatment?_____________

Date of last dental care____________________

How do you feel about the appearance of your teeth?______________________________

Please circle below if you have had problems with any of the following:

*Bad breath *Sensitivity to cold *Sensitivity to hot *Loose/broken filings

*Sensitivity to biting *Sores in mouth *Food collection between teeth *Bleeding gums

*Sensitivity to sweets

The above information is true and accurate to the best of my knowledge.

Signature______________________________________ **Date**__________________

CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

1. **ALL Patients under the Age of 18 must be accompanied by an adult Parent or designated Guardian. Treatment will not be completed if they are not.**

2. I hereby authorize Dr. Friedt or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Friedt to make a thorough diagnosis of (name of patient) ______________________'s needs.

3. Upon such diagnosis, I authorize Dr. Friedt to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to give proper care.

4. I give consent to Dr. Friedt or designated staff use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to pay the amount insurance does not cover within 30 days.

6. **I will provide at least 24 hours notice** in the event that I need to reschedule my appointment.

   -This will allow us to efficiently care for others in need.

____

Patient (Parent/Guardian) Signature Date

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this ______________ day of _______________ 20____________

Print Patient Name____

Signature ____

Relationship to Patient ____