Welcome

Our Goal is for you to Have Healthy Teeth and Gums for Life
Please fill out this form as completely as possible
The better we communicate - the better we can care for you

PATIENT INFORMATION

Patient's Name_____ (First / MI / Last) Gender: ☐M ☐F Birth Date_____ Age_____

Marital Status: ☐Single ☐Married ☐Child

Street Address_____ City_____ St_____ Zip_____

Phone #'s: Please check the best number(s) to be reached at, for both general contacts and confirming appointments. Thank You.

☐ Home: (_____)_____ ☐ Work: (_____)_____ext:_____ ☐ Cell: (_____)_____

Best Time to Call_____ If we can't speak to you directly, is it ok to leave a detailed message? ☐ Yes ☐ No ☐ On Voice Mail? ☐ With other person?

E-Mail Address_____ (for our use only, won't be given out) Social Security #_____

Patient's Occupation_____ If Full-Time College Student - School_____ State_____

Employer Name_____ Work Address_____

Emergency Contact_____ Relationship to Patient_____ Phone_____

REFERRAL INFORMATION

Name of Person, or type of advertisement that referred you to our Office_____

RESPONSIBLE PARTY INFORMATION

☐Check if patient is responsible for account - If not, Responsible Party's relationship to Patient_____

Responsible Party's Name_____ Gender: ☐M ☐F Birth Date_____ Age_____

Street Address_____ City_____ St_____ Zip_____

Phone #'s: Home: (_____)_____ Work: (_____)_____ext:_____ Cell: (_____)_____

E-Mail Address_____ (for our use only, won't be given out) Social Security #_____

INSURANCE INFORMATION (PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND A PHOTO I.D.)

Primary Coverage: Name of Insured_____ Insured's Birth Date_____

Insured's Street Address_____ City_____ St_____ Zip_____

Insured's Social Security #_____ Group #_____ Plan #_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child Insured's Employer_____

Insurance Company Name_____ Ins. Co. Phone_____

Secondary Coverage: Name of Insured_____ Insured's Birth Date_____

Insured's Street Address_____ City_____ St_____ Zip_____

Insured's Social Security #_____ Group #_____ Plan #_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child Insured's Employer_____

Insurance Company Name_____ Ins. Co. Phone_____

AUTHORIZATION, CONSENT AND FINANCIAL AGREEMENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. **I understand that I am responsible for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made, regardless of any insurance coverage I may have**. I also assign all insurance benefits to the Doctor. I authorize release of any information to my insurance company. I further understand that a finance charge may be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child): _____ Date: _____

Health History

Please fill out this form as completely as possible

Patient's Name: _____ Today's Date: _____

Person filling out form (if not patient) _____ Relationship to Pt. _____

Primary Care Physician: _____ Phone #: (____) _____

Other Physician(s): _____
or Specialist(s)

_____ Date of Last Physical: _____

Please check either "Yes" or "No" to indicate if you have, or had, any of the following:

Arthritis ☐Yes ☐No
Artificial Heart Valves ☐Yes ☐No
Artificial Joints ☐Yes ☐No
Asthma ☐Yes ☐No
Auto-Immune disease ☐Yes ☐No
Back / Neck Problems ☐Yes ☐No
Bleeding Problems ☐Yes ☐No
Cancer ☐Yes ☐No
(Type) _____
Chemotherapy ☐Yes ☐No
Circulation Problems ☐Yes ☐No
Congenital Heart Defects ☐Yes ☐No
COPD / Emphysema ☐Yes ☐No
Dementia ☐Yes ☐No
Diabetes ☐Yes ☐No
Dizziness / Vertigo ☐Yes ☐No

Drug Addiction ☐Yes ☐No
Eating Disorders ☐Yes ☐No
Epilepsy ☐Yes ☐No
Fainting ☐Yes ☐No
Headaches ☐Yes ☐No
Heart Disease ☐Yes ☐No
Hepatitis-Type: A B C ☐Yes ☐No
Herpes ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
HIV Positive / AIDS ☐Yes ☐No
Low Blood Pressure ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No
Nervous System Disorders ☐Yes ☐No
Organ Transplants ☐Yes ☐No
Osteoporosis / Osteopenia ☐Yes ☐No
Pacemaker ☐Yes ☐No

Psychiatric Care ☐Yes ☐No
Radiation Treatments ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No
Sexually Transmitted Disease ☐Yes ☐No
Sinus Problems ☐Yes ☐No
Sleep Apnea ☐Yes ☐No
Stroke, TIA ☐Yes ☐No
Thyroid Problems ☐Yes ☐No
Tonsilitis / Tonsilectomy ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Tumors ☐Yes ☐No
Ulcer ☐Yes ☐No

FOR WOMEN:
Are You Pregnant? ☐Yes ☐No
Due Date: _____
Are You Nursing? ☐Yes ☐No

Have you been told to pre-medicate before any dental treatment? ☐Yes ☐No
If Yes, for what reason? _____

DO YOU SMOKE,
or use tobacco products ☐Yes ☐No

Please list any other Condition or Disease not listed above? _____

_____

Medications

List any medications (including vitamins and supplements) you are taking, and the reason for taking it:

_____ _____
_____ _____
_____ _____
_____ _____

Allergies

Are you allergic to any of the following:

Penicillin ☐Yes ☐No
Amoxicillin ☐Yes ☐No
Clindamycin ☐Yes ☐No
Erythromycin ☐Yes ☐No
Tetracycline ☐Yes ☐No

Codiene (Vicodin) ☐Yes ☐No
Ibuprofen (Motrin) ☐Yes ☐No
Naproxen (Aleve) ☐Yes ☐No
Latex Products ☐Yes ☐No
Local Anesthetics ☐Yes ☐No

Please list any additional allergies

_____
_____
_____
_____

Dental History

Please fill out this form as completely as possible

Patient's Name: _____ Today's Date: _____

Person filling out form (if not patient) _____ Relationship to Pt. _____

Reason for Today's visit: _____

How long ago was your last dental Visit: _____

Your last visit was for: ☐Routine check-up ☐Cleaning ☐Other reason (explain) _____

Were x-rays taken? ☐Yes ☐No If no, when did you last have dental x-rays taken? _____

How often do you see a dentist for routine care? _____

Do you currently have any tooth or mouth pain? ☐Yes ☐No If Yes, where is the pain? _____

Are you taking any medication for the pain? ☐Yes ☐No If Yes, what pain medication? _____

Are you taking antibiotics for a mouth infection ☐Yes ☐No If Yes, what antibiotic? _____

Home Care Habits

How often do you brush? _____ How often do you floss?: _____

Type of toothbrush: ☐Soft ☐Medium ☐Hard ☐Unsure ☐Sonic ☐Electric / Rotary

Other home care products: ☐WaterPik ☐Interdental brushes / picks ☐Mouth rinse _____

☐Floss Threaders ☐Home Fluoride ☐Sensitivity products ☐Dry Mouth products

Please check either "Yes" or "No" to indicate if you've had any of the following:

Bad Breath or Taste ☐Yes ☐No	Facial Fractures ☐Yes ☐No	Periodontal Treatment ☐Yes ☐No
Bleeding Gums ☐Yes ☐No	Fingernail Biting Habit ☐Yes ☐No	Root Canal Treatment ☐Yes ☐No
Chipped or Broken Teeth ☐Yes ☐No	Food Traps Between Teeth ☐Yes ☐No	Scaling / Root Planing ☐Yes ☐No
Cold Sores ☐Yes ☐No	Gaps Between Teeth ☐Yes ☐No	Sensitivity to Biting ☐Yes ☐No
Cosmetic Bonding ☐Yes ☐No	Gums Swollen or Tender ☐Yes ☐No	Sensitivity to Cold ☐Yes ☐No
Clenching or Grinding ☐Yes ☐No	Headaches ☐Yes ☐No	Sensitivity to Hot ☐Yes ☐No
Clicking or Popping Jaw ☐Yes ☐No	Jaw Pain or Tiredness ☐Yes ☐No	TMJ problems ☐Yes ☐No
Crowded Teeth ☐Yes ☐No	Lip or Cheek Biting ☐Yes ☐No	Tobacco Product Usage ☐Yes ☐No
Deep Cleaning ☐Yes ☐No	Loose Teeth ☐Yes ☐No	Toothache Pain ☐Yes ☐No
Dentures (Full) ☐Yes ☐No	Mouth Breathing ☐Yes ☐No	Tooth Extraction due to decay ☐Yes ☐No
Dentures (Partial) ☐Yes ☐No	Oral Cancer ☐Yes ☐No	Tooth extraction due to fracture ☐Yes ☐No
Discolored, Stained Teeth ☐Yes ☐No	Orthodontic Treatment ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Dry Mouth ☐Yes ☐No	Pain Around, Near Ears ☐Yes ☐No	Wisdom tooth extraction ☐Yes ☐No

Are you happy with your smile? ☐Yes ☐No

If no, what would you like to change about your teeth and smile? _____

_____

LEADING EDGE DENTAL CENTER, LTD.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

The *Notice of Privacy Practices,* containing a more complete description of the uses and disclosures of my health information, is being made available upon request if should I choose to read it. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the office address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of this Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

____ Home telephone number _____
____O.K. to leave a message with detailed information
____ Leave a message with call-back number only

____ Work or alternate (cell) number_____
____ O.K. to leave a message with detailed information
____ Leave a message with call-back number only

____ I authorize the following persons access to my PHI(Private Health Information)

_____

PLEASE NOTE: A scheduled appointment is a commitment of time between the Doctor and the patient. Therefore we make every effort to help you to keep these commitments.

As a courtesy to our patients we confirm all scheduled appointments one to two days prior to the appointment. This is why we ask that the above form be as complete as possible to allow us to contact you appropriately.

If you find that you are ever unable to keep a scheduled appointment, a 24-48 hour notice will allow us to schedule another patient in need of treatment and to find a more suitable time for you. A minimal charge of **$50.00** may be placed on your account for any broken appointment.

Patient signature:_____Date: _____

Print Name_____

DENTAL BENEFIT EXPLANATION

It is our goal to provide the best dental care for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term "dental insurance" is misleading. What is commonly known as "dental insurance" is more correctly termed dental benefits. Dental benefits are not intended to pay everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage up to a set yearly maximum. The benefits available to you are established by which plan package your employer has purchased.

As a courtesy to you, we will submit your dental treatment claims to your dental plan carrier. We also accept benefit assignment*, meaning that we will make a "best guess" estimate of the expected benefit payment and allow you to pay your estimated portion at the time your services are provided. Please be aware that dental insurance has become increasingly unpredictable and because of that, we do NOT guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans. Any question regarding denials or lack of benefits should be directed to your employer or human resources person to further explain the benefits they have chosen for you.

I understand and agree to these policies regarding my dental benefits.

_____

PATIENT SIGNATURE DATE

*except in such cases that the insurance company will NOT send payment directly to us, ie: Delta Dental