Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ____________
SS#/SIN ____________
Date ____________

Patient Information (CONFIDENTIAL)

Name ____________ Birthdate ____________ Home Phone ____________
Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Email ____________ Cell Phone ____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ____________ City ____________ State/Prov. ____________ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ____________ Work Phone ____________
Business Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________
Whom may we thank for referring you? ____________
Person to contact in case of emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Email ____________ Cell Phone ____________
Driver's License# ____________ Birthdate ____________ Financial Institution ____________
Employer ____________ Work Phone ____________ SS#/SIN ____________
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local# ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Insurance Company ____________ Group# ____________ Policy/ID# ____________
Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local# ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
Insurance Company ____________ Group# ____________ Policy/ID# ____________
Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

Over Please

Patient Medical History

Physician ____________ Office Phone ____________ Date of Last Exam ____________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ____________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ____________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ____________		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ____________	☐	☐
Acid Reflux	☐	☐	Osteoporosis	☐	☐			

Patient Dental History

Name of Previous Dentist and Location ____________ Date of Last Exam ____________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ____________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. 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.

X ____________

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ____________

____________ Signature ____________ Date ____________

DBM Dental Dr. Michael Perry, DDS

HIPAA compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If Yes. Please name the members allowed:______________________________

This consent was signed by:______________________________

PRINT NAME PLEASE

Signature ______________________________ Date ____________

Witness ______________________________ Date ____________

Oral Screening Consent Form

Our Practice (DBM Dental) continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and Alcohol use are other major predisposing risk factors, but more than 25% of oral cancers victims have no such lifestyle with using these risk factors, Oral cancer risk factors are as follows:

Increased risk: patients ages 18-39 - sexually active patients (HPV)

High risk: patients age 40 and older; tobacco uses (any age, any type within 10 years)

Highest risk: patients age 40 and older with lifestyles consisting of using tobacco and/or alcohol

We have recently incorporated Velscope into our oral screening exam. We find that using the Velscope during the oral cancer examination improves our ability to identify suspicious areas at their earliest stages. Velscope is similar to early detection procedures for other cancers such as mammography, Pap Smear, and PSA.

This advanced examination is recognized by the American Dental Association; however, this exam might not be covered by your dental insurance. The fee for this advanced examination is $20.00.

Yes: I authorize the clinician to perform oral cancer detection with the use of the Velscope instrument and accept financial responsibility for this examination.

Print Name: ______________________________

Signature: ______________________________ date: ______________

No: I would prefer not to have the Velscope used at this time. I do however understand the benefits of using this during my dental examination.

Print Name: ______________________________

Signature: ______________________________ Date: ______________

Current Medications List

Name ______________________________ **Date** ______________________________

Emergency Contact Name/Phone: ______________________________

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Allergies

Additional Info

Adopted from: Aging in Stride – Plan Ahead, Stay Connected, Keep Moving · www.AgingInStride.org

COVID-19 (Coronavirus) Disclosure and Informed Consent

I affirm that Dbm Dental, Ltd, Dr. Michael Perry and team members operating within this practice have offered me the opportunity to reschedule my dental treatment to an alternative date. I also affirm that I have freely elected to proceed with my essential or non-essential dental procedure at this time.

I have been made aware by the Practice that while the Practice has implemented several new safety measures to prevent or reduce the spread of the COVID-19 virus, they cannot make any guarantees. The staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since they are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. Therefore, I fully understand that proceeding with the treatment today could potentially have exposure-risk associated with COVID-19.

I understand that acquiring COVID-19 can lead to severe symptoms such as fever, chest pain, shortness of breath and respiratory complications and other associated symptoms. Advanced COVID-19 disease can also lead to prolonged hospitalization, intensive care admission, mechanical ventilation, or even possible death.

I also agree that neither I nor any of my family members/individuals with whom I currently reside with have been exposed to or are experiencing any of the following symptoms in the past 14-21 days.

- Shortness of Breath
- Chest pain
- Fever
- Runny Nose, loss of smell or taste
- Sore Throat
- Fatigue and body aches
- Other symptoms associated with COVID-19
- Confirmed or suspected COVID-19 (coronavirus) infection

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives.
I am consenting to a charge per visit of $10.00 for the office sterilization fee with these new procedures until further notice.

If the patient is under 18, a parent or guardian must sign below to consent to the procedure with full understanding and disclosure of such risks and alternatives.

Patient Name: ____

Guardian Name: ____

Patient/ Guardian Signature: ______________________________________

Date: ____

Patient Screening Form

ADA®

Patient Name:

	PRE-APPOINTMENT	**IN-OFFICE**
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.