ALL SMILES DENTAL CENTER/ WORTH DENTAL ASSOCIATES

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Family History

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Patient's name ______________________ Age____ Birth date __________ Gender__________

Home address ______________________ City/State/Zip__________________

Home Phone ______________________ Work/Cell Phone__________________

Employer or School ______________________ Email Address __________________

Father's Name ______________________ Mother's Name__________________

Address ______________________ Address__________________

Home Phone ______________________ Home Phone__________________

Work Phone ______________________ Work Phone__________________

Place of Employment ______________________ Place of Employment__________________

Occupation ______________________ Occupation__________________

Siblings (Names and Ages) ____

Who does the patient live with (minors) ________________________________

Does the patient have insurance coverage? Y N

If so what is the insurance company? ________________________________

We will be more than happy to check on your orthodontic insurance coverage for you

Name of Insured ______________ **Insured's Birthday** ____________ **SS#**____________

Medical History

Please circle any that apply to the patient

ADD/ADHD	COLDSORES	HEART CONDITIONS	KIDNEY DISEASE	OTHER
ALLERGIES	DEPRESSION	HEAD/FACE INJURIES	LUNG DISEASE	
ANEMIA	DIABETES	HEPATITIS	MOUTH BREATHING	
ARTHRITIS	ENDOCRINE DISORDERS	HERPES	ORAL ULCERS	
ASTHMA	EPILEPSY/SEIZURES	HIV	RHEUMATIC FEVER	
BLEEDING	HEARING PROBLEMS	HOSPITAL STAYS	THYROID PROBLEMS	

Comments on any of the above: ____

____

*Has the patient been under the care of a physician during the past two years, other than for routine examinations? Yes No (Please Circle) If yes, please explain ____________________

____

*Does the patient require pre-medication for dental procedures? Yes No (please circle)

*Please list any current drugs or medications ________________________________

____

Respiratory History

*Has the patient had treatment from an Ear, Nose, and/or Throat Specialist?
If yes, when? ______________________________
*Were tonsils removed? Yes No (please circle)
Is the patient a mouth breather? Yes No (please circle)

Dental History

Who is Patient's general dentist? ______________Phone (___)_____-_________
Address: ______________________________
When was the patient's last dental visit? ______________________________

DO ANY OF THE FOLLOWING PERTAIN TO THE PATIENT?

1) Thumb/finger/lip sucking? Please circle all that apply) Current Past
2) Grinding or clenching of teeth? Yes No
3) Tongue thrusting? Yes No
4) Difficulty in opening mouth wide? Yes No
5) Clicking/soreness/popping in jaw joint? Yes No If yes, please explain__________________

____

*Has the patient ever seen an orthodontist? If so, when? ______________________________
*What is the patient's chief concern about his/her teeth? ______________________________

Please make any additional comments here: ______________________________

____

____

Signature of patient (or parent if under 18 years of age)______________________________
Date_______________

Acknowledgement of Receipt of

Notice of Privacy Practices

"You May refuse to Sign This Acknowledgement"

I,____, have read a copy of this office's Notice of Privacy Practices.

____

Please print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

_______ Individual refused to sign

_______Communications barriers prohibited obtaining the acknowledgement

_______An emergency situration prevented us from obtaining acknowledgement

_______other (lease specify)____

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 care needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information (CONFIDENTIAL)

Date________________

Soc. Sec. #________________

Name________________ Birthdate________________ Home Phone________________

Address________________ City________________ State________ Zip________

Patient's or Parent's Employer________________

Business Address________________ City________________ State________ Zip________

Spouse or Parent's Name________________ Employer________________ Work Phone________________

If Patient is a Student, Name of School / College________________ City________________ State________

Whom May We Thank For Referring You?________________

Person to Contact in Case of Emergency________________ Phone________________

Email________________

Responsible Party

Name of Person Responsible for this Account________________ Relationship to Patient ________________

Address________________ Home Phone________________

Birthdate________________ Is this Person Currently a Patient in our Office? _____ Yes _____ No

Employer________________ Work Phone________________

Insurance Information

Name of Insured________________ Relationship to Patient ________________

Birthdate________________ Social Security#________________ Date Employed________________

Name of Employer________________ Work Phone________________

Address of Employer________________ City________________ State________ Zip________

Insurance Company________________ Group#________________ Union or Local #________

Ins. Co. Address________________ City________________ State________ Zip________

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

Name of Insured________________ Relationship to Patient________________

Birthdate________________ Social Security #________________ Date Employed________________

Name of Employer________________ Work Phone________________

Address of Employer________________ City________________ State________ Zip________

Insurance Company________________ Group #________________ Union or Local # ________

Ins. Co. Address________________ City________________ State________ Zip________

TIME 2:07 PM

Worth Dental Associates

DATE 3/12/2014

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ____________

CONSENT FORM: DENTAL IMPLANT(S)
ALL SMILES

Patient Name: ______________________________

Doctor Name: ______________________________

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Condition

My doctor has explained the nature of my condition to me: Missing tooth or teeth. ________

Procedure – Dental Implant

My physician has proposed the following procedure to treat or diagnose my condition: Dental implant This means: Surgically place an implant into the supporting jawbone.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of surgery and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to ask the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental professionals who place implants.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that my missing tooth or teeth may be replaced with artificial teeth supported by an implant. I hereby authorize and direct the doctor and his authorized associates and assistants to treat my condition. ________
2. The procedure I choose to treat this condition is understood by me to be the placement of root form implant(s). Additional treatment procedures may include a bone graft including materials of human, animal or plant origin. I understand that the purpose of this procedure is to allow me to have more functional artificial teeth by the implants providing support, anchorage and retention for these teeth. ________
3. I understand that this is nonetheless an elective procedure, that such procedures are performed to improve function and that an alternative option, although less desirable, is to not undergo surgery and do nothing. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a bridge, a partial denture, full denture, or other options. I understand and choose to undergo the placement of root form implant(s). ________
4. I understand that my gum tissue will surgically be opened to expose the bone and that implants will be placed immediately by tapping or threading them into holes that have been drilled into my jaw bone. I understand that the gum tissue will then be stitched closed over or around the implant to permit healing for a period of 3 to 6 months. I understand that dentures usually cannot be worn during the first few weeks of the healing phase. I understand that the implants placed will be integrated in 3 to 9 months time, depending on my personal healing ability. ________
5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure contained herein. I therefore authorize and request that the doctor and his associates or assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment. ________
6. I have had the opportunity to discuss with the doctor the planned surgical procedure, implant placement, and my postoperative responsibilities. I understand that following the procedure during the healing process I should not smoke, drink heavily, use any drugs not prescribed by my doctor, should not blow my nose for at least two weeks and thereafter not heavily blow my nose for an additional two weeks. I should take any antibiotics prescribed and use pain medication as needed. If I experience an unusual amount of pain I should contact the doctor or his associates immediately, as it may signify a problem. ________
7. I understand that anesthesia given during surgery and certain prescription medications used after surgery cause drowsiness and impaired physical performance, and that such effect is increased by the use of alcohol, and that I must not operate a motor vehicle or any other hazardous equipment while taking these drugs. Further, I agree not to operate a motor vehicle or any other hazardous equipment for at least 48 hours after my release from surgery. ________

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8. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of surgery, there exists a risk of failure or necessity of additional treatment despite appropriate care. I have been advised that the placement of root form implants has shown long term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. I further understand that should removal be required, the doctor will remove the implant at no additional cost. However, should I elect to have another doctor remove the implant, I am solely responsible for all costs and fees incurred in doing so and hereby release the doctor from any such costs and fees imposed by the other doctor. ______

Alternatives

My physician has explained the following medically acceptable alternatives to be: A bridge, a partial denture, full denture, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done. ______

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same, improve, or get worse. It is the doctor's opinion that the proposed procedure is a better option for me. If I don't have the procedure, the following may also happen:

Further loss of supporting tissues or bone. ______

A gap in the teeth. ______

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks, in his articulable professional opinion, are better to do at this sitting rather than later on. ______

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: Restricted mouth opening; gum shrinkage; clicking or pain of the temporomandibular joints (jaw joints) tooth sensitivity to hot or cold for days up to months; loose teeth; food lodging between the teeth requiring flossing for removal; and unesthetic exposure of crown margins of teeth in the surgery area. These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Interference with speech sounds; permanent nerve injury possibly requiring nerve graft surgery.

There will be no refund of fees from the surgeon or restorative dentist in the event of complications requiring additional surgery to salvage the implant or failure requiring removal of part or all of the implant. Should removal be required, the doctor will remove the implant at no additional cost. If I have someone else remove the implant, I am responsible for all costs and fees and will not ask the doctor to pay for it. ______

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Xanax, Halcion, Versed, Demerol, fentanyl or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out. ______

Implant Database

If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes. ______

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Even though the dentist will make every effort to preserve natural teeth, occasionally, treated teeth may require extraction.

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I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor. ________

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls. ________

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records. ________

Miscellaneous

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively. ________

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees. ________

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

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I authorize Dr. ______________________________ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above. I know that I am free to withdraw from treatment at any time.

______________________________ ______________________________
Patient or Representative Signature ***Date***

If not the patient, what is your relationship to the patient?

____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

______________________________ ______________________________
Dentist Signature ***Date***

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