ALMA HERITAGE DENTISTRY

Welcome!

Thank you for selecting our friendly and caring dental team! Our goal is to provide you with the best possible care in the most relaxed atmosphere! So that we can meet all your needs, please fill out these forms completely and ask us if you need any assistance - we are happy to help!

Patient Name _____ Age_____Date of Birth _____

Address_____City, State, Zip _____

Home Phone No._____Cell Phone No._____Work Phone No._____

Social Security No._____Email_____

Best Contact: ❑ Email ❑ Cell ❑ Text ❑ Home

Employer_____Employer Address_____

If applicable-Spouses Name_____Spouse's Phone: Work_____Cell_____

Emergency Contact:_____ Relation_____ Emergency Phone_____

Name of Person Responsible for this Account_____Relation to Patient_____

Address_____Home Phone No._____

Email _____ Cell Phone No. _____

Driver's License No._____ Date of Birth_____ Financial Institution_____

Is this person currectly a patient in our office? ❑ Yes ❑ No

Dental Benefits:

Do you have dental insurance: ❑Yes ❑ No Subscribers Name_____

Subscriber's SS#_____ Subscriber's Date of Birth _____

Relation to Patient_____Employer/Co. Name_____Phone No._____

Employer/Co. Address, City, State, Zip_____

Insurance Carrier's Name_____ID/ContractNo_____Group No._____

Insurance Carrier's Address, City, State, Zip_____Phone No. _____

Whom may we thank for referring you to our practice?_____

Would you like to receive appointment reminders via text message ❑ Yes ❑ No

Please "like" **Alma Heritage Dentistry** on Facebook to receive special offers.

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company, We are not a party to that contact. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deducible due, to Alma Heritage Dentistry, at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patients responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payments(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

Name _____ Date _____

CONSENT FOR TREATMENT

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

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's 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 unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

ALMA HERITAGE DENTISTRY

CONFIDENTIAL MEDICAL HISTORY

GENERAL HEALTH: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

❒ Y ❒ N Under a physician's care now? Physician's Name & Address: _____

❒ Y ❒ N Any hospitalization in the past 5 years? _____

❒ Y ❒ N Any serious illnesses/surgeries? _____

❒ Y ❒ N Use tobacco in any form? If yes, what type: _____

❒ Y ❒ N Is pre-medication required before dental visits due to heart condition or artificial joint?

❒ Y ❒ N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ❒ Y ❒ N Currently nursing? ❒ Y ❒ N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ❒ Y ❒ N
If yes, please decribe:

_____

Is there anything important about your medical condition we have not asked? ❒ Y ❒ N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) ❒ NONE

- ❒ ACID REFLUX
- ❒ ADHD
- ❒ AIDS/HIV
- ❒ ANEMIA
- ❒ ANOREXIA
- ❒ ANXIETY
- ❒ ARTIFICIAL HEART VALVE
- ❒ ARTIFICIAL JOINTS
- ❒ ARTHRITIS
- ❒ ASTHMA
- ❒ AUTISM/ASPERGER'S
- ❒ BLEEDING DISORDER
- ❒ BULIMIA
- ❒ CANCER/MALIGNANCY
- ❒ CEREBRAL PALSY
- ❒ CHEMICAL DEPENDENCY
- ❒ CHICKEN POX
- ❒ CONVULSIONS
- ❒ DEPRESSION
- ❒ DIABETES
- ❒ DIZZINESS/FAINTING
- ❒ EPILEPSY/SEIZURES
- ❒ FREQUENT EAR INFECTIONS
- ❒ FREQUENT HEADACHES
- ❒ HEARING PROBLEMS
- ❒ HEART ATTACK
- ❒ HEART DISEASE
- ❒ HEART MURMUR
- ❒ HEPATITIS
- ❒ HIGH BLOOD PRESSURE
- ❒ KIDNEY DISEASE
- ❒ LIVER PROBLEMS
- ❒ MITRAL VALVE PROLAPSE
- ❒ MONONUCLEOSIS
- ❒ PACEMAKER
- ❒ EXCESSIVE DAYTIME SLEEPINESS
- ❒ PSYCHIATRIC TREATMENT
- ❒ RADIATION/CHEMO
- ❒ RESPIRATORY DISEASE
- ❒ RHEUMATIC FEVER
- ❒ SINUS PROBLEMS
- ❒ STROKE
- ❒ THYROID CONDITION
- ❒ TUBERCULOSIS
- ❒ ULCERS
- ❒ VENEREAL DISEASE
- ❒ SLEEP APNEA OR SNORING
- ❒ OTHER - PLEASE LIST: _____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY) ❒ NONE

- ❒ ASPIRIN
- ❒ ANESTHETIC - LOCAL
- ❒ BARBITURATES
- ❒ CODEINE
- ❒ DAIRY
- ❒ LATEX
- ❒ LACTOSE INTOLERANCE
- ❒ METAL SENSITIVITY
- ❒ NITROUS OXIDE SEDATION
- ❒ SLEEPING PILLS
- ❒ SULFA DRUGS
- ❒ PENICILLIN/OTHER ANTIBIOTICS
- ❒ OTHER - PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) ❒ NONE

- ❒ ANTIBIOTICS/SULFA DRUGS
- ❒ BLOOD THINNERS
- ❒ INSULIN
- ❒ OTHER DIABETIC MEDICATIONS
- ❒ ANTIHISTAMINE/ALLERGY
- ❒ CANCER/CHEMO MEDICATIONS
- ❒ NITROGLYCERIN
- ❒ RECREATIONAL DRUGS
- ❒ DAILY ASPIRIN
- ❒ CORTISONE/STEROIDS
- ❒ ORAL CONTRACEPTIVES
- ❒ THYROID MEDICATIONS
- ❒ BLOOD PRESSURE MEDICATIONS
- ❒ HEART MEDICATION/DIGITALIS
- ❒ OSTEOPOROSIS MEDICATIONS
- ❒ TRANQUILIZERS
- ❒ OTHER (PLEASE LIST BELOW OR PROVIDE A LIST FOR US)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____ _____

PATIENT NAME DATE

ALMA HERITAGE DENTISTRY

Confidential Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs

ARE ANY OF YOUR TEETH SENSITIVE TO:	**Yes**	**No**
Hot or cold?	❒	❒
Sweets?	❒	❒
Biting or Chewing?	❒	❒
Have you noticed any mouth odors or bad taste?	❒	❒
Do you frequently get cold sores?	❒	❒
Do you frequently get oral ulcers?	❒	❒
Do your gums bleed or hurt?	❒	❒
Have you noticed any loose teeth?	❒	❒
Have your teeth shifted over the years?	❒	❒
Does food tend to become caught in between your teeth?	❒	❒

DO YOU?		
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning	❒	❒
Have a hard time opening wide?	❒	❒
Mouth breathe while awake or asleep	❒	❒
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	❒	❒
Snore, been diagnosed with sleep apnea or have difficulty sleeping?	❒	❒

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?		
Clicking or popping of the jaw?	❒	❒
Pain in the jaw joint area near the ear?	❒	❒
Difficultly in opening or closing your mouth?	❒	❒
Headaches, neck aches, or shoulder aches frequently?	❒	❒

HAVE YOU EVER HAD: Please check those that apply!

- ❒ Orthodontic treatment?
- ❒ Periodontal or gum treatment?
- ❒ Oral Surgery?
- ❒ Bite Adjustment or has been ground?
- ❒ Serious injury to the mouth or head?
- ❒ Mouth guard or bite splint?

When was your last dental visit?_____ Previous Dentists Name?_____

What was completed during your last dental treatment?_____

How often do you brush your teeth?_____ How often do you floss? _____

What other dental aids do you use? (electric toothbrush? Brushes? Toothpicks?) _____

Do you have any dental problems that you are aware of? If yes, please describe?_____

_____

Do you feel nervous about having dental treatment? If yes, what is your biggest concern? _____

I WOULD LIKE TO LEARN MORE ABOUT:

- ❒ Orthodontics or Invisalign?
- ❒ Cosmetic Dentistry?
- ❒ Implants?
- ❒ Whitening Bridges?
- ❒ Crowns?
- ❒ Bridges?
- ❒ Veneers?
- ❒ Dentures?
- ❒ Other_____