ADVANCED FAMILY DENTISTRY
PATIENT INFORMATION

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Previous Dentist: _____ Dental Office: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

AUTHORIZATION OF INSURANCE PAYMENT:

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of information on this page.

_____ _____

PATIENT OR GUARDIAN SIGNATURE Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing. I acknowledge that I have received a copy of Advanced Family Dentistry's Notice of Privacy Practices. This notice describes how Advanced Family Dentistry may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.
I attest to the accuracy of the information on this page.

_____ _____

PATIENT OR GUARDIAN SIGNATURE Date

ADVANCED FAMILY DENTISTRY

CONSENT TO TREATMENT

I hereby authorize Dr. Jessica T. Wertz and whomever she may designate as her assistants, to perform upon me the diagnostic procedures and treatment necessary for proper dental care and if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgement, for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

I consent to the Dental Treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss of loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. , numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics of any other drugs that may be deemed necessary in my case and under that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions). cardiac arrest and aspiration; and thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to the blood vessels and nerves which may be causes be injections of any medications or drugs.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

I realize that in spite of the possible complications, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation of procedure.

I realize that is is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

_____

PATIENT NAME (PLEASE PRINT)

_____ _____

PATIENT OR GUARDIAN SIGNATURE Date

ADVANCED FAMILY DENTISTRY
MEDICAL HISTORY

PATIENT NAME:

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, cigar smoking or chew tobacco	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in you mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Medical Doctor Name: _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control pills? ☐ Yes ☐ No

Check (✓) If you have or have had any of the following:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Cholesterol Problems
☐	☐	Congenital Heart Defect
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Eating Disorder
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+/AIDS

Y	N	Conditions
☐	☐	Heart Murmur
☐	☐	Heart Problems/Surgeries
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pacemaker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Care
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Tumor
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Other _____

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry or Metals
☐	☐	Latex
☐	☐	Sulfa
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

List medications and herbal or dietary supplements you are currently taking and for what condition: _____

_____

_____

_____

_____

_____

PHARMACY NAME _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Date _____ Patient or Guardian Signature _____

Date _____ Doctor Signature _____