Patient Information

Name _____ Married ☐ Single ☐ Minor ☐ Other ☐

Birth Date_____ Social Security No._____ I identify my gender as: _____

Address _____ Zip code: _____

Cell phone(_____)_____ Email_____

Emergency Contact: Name _____ Phone(_____)_____

1. ***Preliminary Consent for Treatment***
   I understand I am having any or all the following done today: Exam, Radiographs "X-rays" and cleaning "Prophylaxis"

   Initials _____

2. ***Medications , Substances, and Medical Conditions***
   I understand that antibiotics, analgesics "pain medicines", anesthetics, latex and other substances can cause allergic reactions, resulting in redness and/or swelling of the tissue, itching, pain, vomiting and /or more severe allergic reactions. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs. I have informed the Dentist of any known allergies and/or medical conditions, including possible pregnancy.

   Initials _____

3. ***Office Policy Regarding Appointments***
   We understand that circumstances can sometimes prevent you from coming to a scheduled appointment. However, out of respect for our other patients attempting to secure appointments, if you are unable to keep an appointment, we kindly ask for two days' notice. There will be a $50 fee for any cancellations made within 24 hours of your reserved appointment. We appreciate your understanding.

   Initials _____

4. ***Disclosure of Records***
   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.

   Initials _____

5. ***Dental Benefits / Payment Authorization***
   I understand that treatment my Dentist recommends is based on what he/she determines is best for my dental health, and not necessarily based on what an insurance plan will pay. Therefore I understand that my Insurance (if any) may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered by the insurance plan. I understand that the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequency limitations, group coverage, incomplete information provided by my insurance company, etc. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I acknowledge that I am responsible for any balance remaining in the event that my insurance coverage is terminated for any reason. In addition, I am aware any co-payments or payments will be due the day of treatment.

   Initials _____

_____ _____

Date **Patient Signature/Guardian Signature**

CLEARLY CARES DENTAL

Medical History

Please circle the appropriate answer, if you do not know the correct answer please write "DON'T KNOW" on the line after the question.

Patient Name _____ Birth Date _____

1. Physician'sName _____
   Address: _____
   Telephone: _____
2. Are you under a physician's care? ..... Y N
   Since when_____ Why? _____
3. When was your complete physical exam? _____
4. Are you taking any medications or substances? ..... Y N
   (If yes, please list medications in comments box.)
5. Do you routinely take health related substances?(Vitamins, herbal supplements, natural products)... Y N
6. Are you allergic to any medications or substances? (Please list)..... Y N
7. Do you have any allergies or hives? ..... Y N
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?..... Y N
9. Are you sensitive to any metals or latex? ..... Y N
10. Are you pregnant or suspect you may be?..... Y N
11. Do you use any birth control medications? ..... Y N
12. Have you been treated for or been told you might have heart disease? ..... Y N
13. Do you have a pacemaker, an artificial heart valve implant, or Been diagnosed with mitral valve prolapse? ..... Y N
14. Have you ever had rheumatic fever? ..... Y N
15. Are you aware of any heart murmurs? ..... Y N
16. Do you have high or low blood pressure? (please circle which type)..... Y N
17. Have you ever had a serious illness or major surgery? ..... Y N
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... Y N
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (biophosphonates) for bone tumors, excessive calcium in you blood or osteoporosis?..... Y N
20. Do you have inflammatory diseases, such as arthritis or rheumatism?..... Y N
21. Do you have any artificial joints/prosthesis?..... Y N
22. Do you have any blood disorders, such as anemia, leukemia, etc?..... Y N
23. Have you ever bled excessively after being cut or injured?..... Y N
24. Do you have stomach problems?..... Y N
25. Do you have any kidney problems?..... Y N
26. Do you have any liver problems?..... Y N
27. Are you diabetic?..... Y N
28. Do you have fainting or dizzy spells?..... Y N
29. Do you have asthma?..... Y N
30. Do you have epilepsy or seizure disorders?..... Y N
31. Do you or have you had venereal or any sexually transmitted disease?..... Y N
32. Have you tested HIV positive?..... Y N
33. Do you have AIDS?..... Y N
34. Have you had or do you test positive for hepatitis?..... Y N
35. Do you or have you had T.B.?..... Y N
36. Do you smoke, chew, or snuff or any other forms of tobacco?..... Y N
37. Do you regularly consume more than one or two alcoholic beverages a day?..... Y N
38. Do you habitually use controlled substances?..... Y N
39. Have you had psychiatric treatment?..... Y N
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with Phentermine (fen-phen), dexafenfluramine (redux) or other weight loss products?..... Y N
41. Do you have any disease, condition, or problem not listed?..... Y N
    If so, explain _____
42. Is there anything else we should know about your health that we have not covered? Y N
    _____
43. Would you like to speak to the Doctor privately about any problems?..... Y N

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN SIGNATURE _____ DATE_____

DENTIST'S SIGNATURE _____ DATE_____

Clearly Cares Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
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 acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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