

PATIENT HISTORY

Date: ____ - ____ - ____

Legal Name: _____ DOB: ____ - ____ - ____

Name you prefer to be called: _____

Social Security #: ____ - ____ - ____

How did you hear about our office?

Address: _____ City: _____ State: _____

Zip: _____

Home Phone: () ____ - ____ Work Phone: () ____ - ____

Cell Phone: () ____ - ____ Preferred Contact #: Home Work Cell Email

Email Address: _____

Employer: _____

Occupation: _____

Emergency Contact Person: _____ Relation: _____

Home Phone: () ____ - ____ Alternate Phone: () ____ - ____

Marital Status: _____ Spouse's Name: _____

Social Security #: ____ - ____ - ____ DOB: ____ - ____ - ____

Spouse's Employer: _____ Occupation: _____

Work Phone: () ____ - ____ Cell Phone: () ____ - ____

Do you have dental insurance? ____

Primary Insured: _____

Is there a secondary dental insurance plan? ____

Secondary Insured: _____

Please present your insurance card to our front staff to verify coverage and benefits.

MEDICAL HISTORY

How would you rate your health? Excellent Good Fair Poor

Are you currently under the care of a physician other than for routine care? ____NO ____YES

If yes, please explain:

Have you been hospitalized in the past year? ____NO ____YES

If yes, please explain:

Name of your physician: _____ Phone: () _____ - _____

Address: _____ Date of last complete exam? ____ - ____ - ____

* Please check any of the following that you have had or have at present:

- | | | |
|--|--|--|
| <input type="checkbox"/> Artificial Joints (hip, knee, etc.) | <input type="checkbox"/> Oral Cancer | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rheumatic or Scarlet Fever | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Synthetic Vascular Heart Graft | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Infectious Endocarditis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Hemodialysis Patients w/ Fistula or Shunt | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neuro-surgical Shunts | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Portocaval Shunts | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Heart Murmur (Organic) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Murmur (Func./Innocent) | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Failure or Disease | <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> ARC | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Yellow Jaundice |
| | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hyperactivity |

Are you allergic to or have adversely reacted to any of the following?

- Aspirin Tylenol Latex Penicillin Keflex
- Erythromycin Local Anesthetic Tetracycline Ceclor
- Clindomycin Doxycycline Amoxicillin Z-Pack (Zithromycin)
- Minocycline Augmentin Cephalexin Biaxin (Clarithromycin)
- Ampicillin

Informed Consent for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infections in need of medication, follow-up procedures or other treatment
3. Temporary or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to the adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult your physician if necessary.

The patient is a part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

If you are contemplating having a tooth removed (extraction) or gum and bone surgery (periodontal surgery) and are taking orally or IV or have taken orally or IV Fosamax (Alendronate) or Actonel (Risedronate) or Boniva (Ibandronate) or Bonefos (Clodronate) or Aredia (Pamidronate) or Zometa (Zoledronic acid). Then this area may not heal ever, resulting in non-healing exposed bone (osteonecrosis or recalcitrant non-healing bone or osteochemonecrosis or ONJ). Please consult your physicians etc. prior to asking your dentist to remove (extract) a tooth and or do gum and bone surgery (periodontal surgery).

In an effort to control the increasing costs of dental care, any claims or disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office of DentistSaintPetersburg.com, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement [including associates]) shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect.

This form is intended to provide you with any overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient (Print) _____

Signature _____ Date _____

Witness (Print) _____

Signature _____ Date _____

Parent / Legal Guardian (Print) _____

Signature _____ Date _____

DentistSaintPetersburg.com : NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

*At DentistSaintPetersburg.com, we have always kept your health information secure and confidential.

*The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

*We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer. We may share your information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

*We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you of your appointments. If you are not home we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.

*We may release some or all of your health information when required by law. If this site is sold, your information will then become property of the new owner.

*Except as described above, this practice will not disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

*You have the right to know of any uses or disclosures we make with your health information beyond normal uses. As we need to contact you from time to time, we will use whatever address and telephone number you have provided. You have the right to transfer copies of your health information to another practice. We will mail your files for you.

*You have the right to see and receive a copy of your of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, there may be a charge of a reasonable fee for the copies.

*You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

*You have the right to receive a copy of this notice.

This notice goes into effect as of November 20, 2011.

I, the undersigned give my authorization for DentistSaintPetersburg.com to obtain records needed from my insurance carriers/providers.

Acknowledgment & Consent

I have received a copy of DentistSaintPetersburg.com Notice of Privacy Practices.

Signed: _____ Print Name: _____ Date: _____

If signing as a parent or guardian, please note the name of the patient _____

Authorization to Release Information

Please include below any person(s) authorized to speak to DentistSaintPetersburg.com concerning your account and/or treatment.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____