BUCKWALTER
DENTAL CARE
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Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out these forms as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factors that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Name:______________________________________ I prefer to be called: __________________Date of birth: ____/____/________

SEX: Male Female **MARITAL STATUS**: Single Married Widowed Divorced Separated Partnered SSN: ________________________

Address: ____ City, State, Zip: ____

Home Phone:________________________ Cell Phone: ________________________ Work Phone: ________________________

Responsible Party: __________________________**Date of Birth**: _____/_____/_____**RELATIONSHIP**: Self Spouse Parent Other

Occupation: _______________________________________ Place of Employment: _____________________________________

Emergency Contact: ___________________________________ **Phone Number**: ____

Email Address: ____

How did you hear about our practice? ____

(If someone referred you to our practice, please write down their name so that we can thank them)

DENTAL INSURANCE (please present card(s) to the front desk)

Primary Dental Insurance: ____________________________________ Relationship to subscriber: _________________________

ID: ________________________________ Group Name: ____________________ Group #: ______________________________

Subscriber Name: ___________________________ **Date of birth**: __________________ **SSN**: ______________________________

Secondary Dental Insurance: ___________________________________ Relationship to subscriber: ________________________

ID: ________________________________ Group Name: _____________________ Group #: ______________________________

Subscriber Name: ____________________________ **Date of birth**: _________________ **SSN**: _____________________________

FINANCIAL AGREEMENT (please review and sign below)

- I authorize Buckwalter Dental Care to release my information to my insurance company and receive payment directly from them.
- If my insurance does not pay as expected, I understand that I will be responsible for any outstanding balance.
- I understand that my portion of payment will be due at the time of service.
- I understand that if I begin major treatment that involves lab work, I will be responsible for that fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- I am aware that there may be a fee charged for appointments broken without 24 hour notice.
- I am aware that treatment plans may change and I will be responsible for the work actually done.

Patient Signature: ____ Date: ________________

Parent/Legal Guardian (If patient is under 18 years of age)

Print Name: ____ Relationship: _______________

NOTICE OF PRIVACY PRACTICES ACKNOLEDGEMENT (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

- Protected health information may be disclosed or used for treatment among other providers who may be involved in that treatment directly and indirectly
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

Patient Signature: ____ Date: ________________

Parent/Legal Guardian (If patient is under 18 years of age)

Print Name: ____ Relationship: ___________________

MEDICAL HISTORY

Patient Name: ____ Date of Birth: ________/________/___________

Do you have a physician? **Yes No** Physician's Name: ____________________________________ Phone: _______________________

Please list all medications that you take: __________________________ _______________________ _________________________

__________________________ _______________________________ _______________________ _________________________

__________________________ _______________________________ _______________________ _________________________

Have you ever been hospitalized or had a major operation? **Yes No** Please explain: ____

Have you ever had a serious head or neck injury? **Yes No** Please explain: ____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? **Yes No**

Do you or have you ever used tobacco in any form? **Yes No** If yes, how much & for how long? _______________________________

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 Codeine Dental Anesthetics Erythromycin Ibuprofen/Motrin Jewelry/Metals Latex Penicillin Tetracycline Vicodin

Have you had any of the following conditions? Please circle Yes or No

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Alcohol or Drug Abuse	Yes	No	Difficulty Breathing	Yes	No	Hepatitis	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Angina	Yes	No	Epilepsy or Seizures	Yes	No	High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Arthritis	Yes	No	Excessive Bleeding	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Artificial Joints/Valves	Yes	No	Fainting/Dizziness	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Breathing Problems	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Chemotherapy	Yes	No	Heart Murmur	Yes	No	Pain In Jaw Joints	Yes	No			
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Psychiatric Care	Yes	No			
Congenital Heart Disease	Yes	No	Heart Surgery	Yes	No	Radiation Treatments	Yes	No			

Have you ever had any serious illness not listed above? **Yes No** ____

Dental History

Why have you come to our office today? __________________________________ Are you in pain? **Yes No** Explain: __________________

Previous Dentist: ______________________________ Phone: _____________________ Last visit date: ___________________________

Have you ever been told that you require antibiotics before dental treatment? **Yes No**

Bad Breath	Yes	No	Dry Mouth	Yes	No	Orthodontic Treatment	Yes	No
Bleeding Gums	Yes	No	Grinding Teeth	Yes	No	Pain When Brushing	Yes	No
Blisters on lips or in mouth	Yes	No	Swollen/Tender Gums	Yes	No	Periodontal Treatment	Yes	No
Broken Fillings	Yes	No	Jaw Pain	Yes	No	Sensitivity	Yes	No
Clenching of Teeth	Yes	No	Lip/Cheek Biting	Yes	No	Snoring	Yes	No
Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No	Sores in Mouth	Yes	No

On a scale of 1-10, how would you rate your smile (10 being the best)? ____________ Would you like whiter teeth? _____________________

Do you feel anxiety about dental treatment? Yes No On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? ____________

To the best of my knowledge, the questions on this forms 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 or guardian **Date**