Welcome to PIPER FAMILY DENTISTRY

Patient's Name _____ Today's date _____

Patient's Date of Birth _____ Patient's Social Security # _____

Home Phone # _____ Cell # _____ Work _____

Street Address _____ City _____ State ____ Zip _____

Email _____ Who may we thank for your referral? _____

Name of Primary Insured _____ Relationship to Patient _____

SS# of Primary Insured _____ Date of Birth of Primary Insured _____

Name of Secondary Insured _____ Relationship to Patient _____

SS# of Secondary Insured _____ Date of Birth of Secondary Insured _____

Responsible Party's Marital Status: O Single O Married O Divorced O Other

Name of Dental Insurance Company _____ Group # _____

Insurance Phone # _____ Name of Employer _____

This office will gladly submit for the insurance benefits, however you are responsible for any co-payment, deductible and balance that the insurance does not cover. It is our office policy for payment at the time of service. If insurance is involved we will expect your estimated percentage. Our office will not be held responsible for inaccurate insurance estimates. Although we will submit claims to secondary insurance carriers, this office will not be held responsible for billing to any secondary family members, estranged spouses, or other additional parties. The primary insured will be responsible for any payment owed this office after the insurance benefits and will also be responsible for obtaining reimbursement from any secondary party. Monthly charges will be added to an unpaid balance after 120 days at the rate of 18% APR of unpaid balance. Returned check fee is $20.00. Accounts with multiple broken appointments will be charged. In the event that this account must be turned over to a professional collection agency, you will be responsible for their charges as well as your unpaid balance for our services.

SIGNATURE OF PATIENT _____

I, HEREBY, AUTHORIZE PIPER FAMILY DENTISTRY TO BILL MY INSURANCE CARRIER FOR SERVICES RENDERED AND RECEIVE PAYMENT DIRECTLY FROM THE INSURANCE COMPANY FOR SUCH SERVICES

Signature _____.

In case of Emergency, whom may we call? Name _____ Phone _____

Relationship to Patient _____ Physician _____ Phone _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth : _____

I have received Piper Family Dentistry's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise my rights, and the practice's legal duties with respect to my information.

I understand that Piper Family Dentistry reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain Piper Family Dentistry's current Notice of Privacy Practices on request.

Signature _____ Today's Date _____

If signed by personal representative of patient, relationship to patient: _____

OFFICE USE: NAME: _____ ID # _____ DOB _____

PIPER FAMILY DENTISTRY

DENTAL AND MEDICAL HISTORY

Name _____ Today's Date _____

What is the reason for your visit today? _____

What do you consider to be your dental problems? _____

In general, how fearful of dental care are you? Not fearful Slightly Fearful Moderately Fearful Extremely Fearful

Which of the following, if any, bother you? Needles Sounds Smells Vibration "Everything"

Have you had an upsetting or unpleasant dental experience? Yes No

If yes, please describe _____

Date of last dental visit : _____ Last dental cleaning: _____ Last x-rays: _____

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

What other dental hygiene methods do you use? (Sonicare, toothpick, etc) _____

Do you use daily fluoride? Yes No If yes, what type? Toothpaste Prescription toothpaste Tablets Gel

Please check yes or no to the following questions:

	Y	N		Y	N
Are your teeth sensitive to hot or cold?			Have you ever had orthodontic treatment?		
Are your teeth sensitive to sweets?			Have you ever had oral surgery?		
Are your teeth sensitive to biting or chewing?			Have you ever had periodontal (gum) surgery?		
Do your teeth ever "just hurt?"			Have you ever had a nightguard or mouthguard?		
Have you noticed any mouth odors or bad tastes?			Have you ever had antibiotics before dental care?		
Have you noticed any bleeding gums?			Have you ever had sedatives for dental care?		
Have you noticed loose teeth or a change in your bite?			Have you ever had a serious injury to the mouth or head?		
Have you noticed food getting caught between your teeth?			Have you ever had clicking or popping in your jaw?		
Have you noticed any lesions, blisters, sores, or pimples?			Have you ever had pain in your jaw joint, ear or face?		
Have you had a lot of cavities?			Have you ever had difficulty opening or closing the mouth		
Have you had an increase in how quickly you get cavities			Have you ever had difficulty chewing?		
Have you had a dry mouth?			Have you ever had head, neck or shoulder aches?		
Are you satisfied with your teeth's appearance?			Have you ever had sore neck, shoulder or face muscles?		
Are you satisfied with your smile?			If you wear dentures, are you satisfied with them?		
Are you satisfied with your facial structure/profile?			Have you had the dentures longer than 5 years?		
Do you bite your lips or cheeks regularly?			If your child has special needs:		
Do you clench, /grind teeth while awake or asleep?			Do you expect them to be cooperative?		
Do you have tired jaws, especially in the morning?			Will any kind of mild restraint be necessary?		
Do you frequently get cold sores?			Can you effectively brush their teeth?		
Do you get blisters or other mouth ulcers?					

MEDICAL HISTORY

	Y	N		Y	N		Y	N
Heart disease/heart failure			Emphysema			Fainting / dizzy spells		
Congenital heart malformation			Chronic cough			Nervous / anxious		
Heart murmur			Shortness of breath			Psychiatric / Psychological care		
Chest pain / angina			Pneumonia			Lupus		
Heart attack /Myocardial infarct			Tuberculosis			Other autoimmune disease		
Cardiac arrhythmia			Thyroid problems			Immunosuppressant therapy		

OFFICE USE: NAME: _____ ID # _____ DOB _____

	Y	N		Y	N		Y	N
Pacemaker / defibrillator			Diabetes			Use of prednisone or similar		
Mitral valve prolapse			Kidney disease			Multiple sclerosis		
Other heart valve issues			Kidney dialysis			Cancer		
High blood pressure			Hepatitis			Radiation therapy		
Low blood pressure			Other liver disease			Chemotherapy		
Swollen ankles			Jaundice			HIV		
Hemophilia			Diet (special / restricted)			Sexually transmitted disease		
Bleeding problems			Ulcers			Trauma		
Bruise easily			Gastric Reflux / Heartburn			Osteoporosis		
Low platelets			Colitis			Artificial joints (hip, knee, etc)		
Anemia			Stroke			Glaucoma		
Transfusions			TIA			Sinus trouble		
Sickle cell disease			Neurologic changes			Hay fever		
Asthma			Epilepsy			Migraine Headaches		
Bronchitis			Seizures			Cold sores / fever blisters		

Have you ever smoked cigarettes? Yes, currently Yes, in the past, but quit No

If yes, how many packs/ cigars / dips per day: How many years?_____

Do you smoke cigars or pipes? Yes No Do you chew tobacco? Yes No

Do you drink alcohol? Yes No If yes, how much? _____

Have you ever abused alcohol or prescription / street drugs? Yes No If yes, what substances? _____

Have you ever had a problem with excessive bleeding or bruising following a tooth extraction or oral surgery? Y N

Women: Some medications used in dentistry will cross the placental and breast milk barrier, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? Yes, _____ Months No Possibly or Not sure Do you use birth control pills? Y N

Are you breast-feeding? Y N Have you ever had an injection for birth control? Y N

Birthday: _____ Age: _____ Height: _____ Weight: _____

How would you estimate your general health to be? Excellent Good Fair Poor

What do you consider to be your most important health issues?

Who is your personal physician? _____ Their telephone: _____

List all medications you are currently taking:

_____

_____

Please list all operations you have had:_____

_____

Please list any allergies and/or bad reactions you have had:

_____

_____

I have read and understood the questions on the health history. I have answered them to the best of my ability.

Signature _____

Signature of Legal Guardian, if applicable _____

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