**Full Heart Dentistry**
**1299 Portland Ave Suite 4**
**Rochester NY 14621**

**Today's Date_____**

## Patient Information

Prefix □Dr. □ Mr. □Mrs. □Ms.
Name _____
Address_____
City _____ State____ Zip_____
Home Phone _____
Cell Phone _____
Email _____

DOB _____
SSN _____

□Male □Female

□ Married □ Single
□ Divorced □ Widowed

**Preferred Contact: □ Home □ Cell □ Email □ Mail**

Business/Employer/School _____
Address _____
City _____ State____ Zip_____
Phone _____

**Responsible Party for Account: □ Self □ Other (print name) _____**

**Insurance Information**
Policy Holder's Name _____ DOB_____ SSN_____
Policy Holder's Employer_____
Insurance Company_____
Insurance Company Address _____
City _____ State_____ Zip_____
Insurance ID Number _____

**Who may we thank for referring you? □Friend/Relative_____**

**□Other _____**

**Reason for Appointment: □Exam □Emergency □Consultation □Other_____**

**Medical Doctors Name _____ Phone Number: _____**

**Name of Previous Dentist _____**

**Pharmacy _____ Phone Number: _____**

**Emergency Contact _____ Phone Number:_____**

# Dental History

It is important that we know about your medical and dental history. These facts have direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

**Are you allergic to or have had an adverse reaction to any of the following medications? (CIRCLE)**

| | | |
|---|---|---|
| **Aspirin** | **Penicillin** | **Epinephrine** |
| **Codeine** | **Sulfa** | **Nitrous Oxide** |
| **Local Anesthetic** | **Erythromycin** | **OTHER_____** |

— Do you have a specific dental problem? Explain _____
— When was your last routine dental exam? _____
— Describe your present dental health: _____
— Do you think you have active decay or gum disease? _____
— Do you gums ever bleed? If yes, when? _____
— Do you brush and floss on a routine basis? _____
— Do you want to keep your remaining teeth? _____

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Nursing /Pregnant, Weeks: _____ | ☐ | ☐ | Dental Implants |
| ☐ | ☐ | Smoker, Frequency and Amount: _____ | ☐ | ☐ | Clicking, Popping, Discomfort in Jaw Joints (TMJD) |
| ☐ | ☐ | Dentures: Full / Partial | ☐ | ☐ | Sensitivity to: Sweets, Hot, Cold/Pressure |
| ☐ | ☐ | Have / Had Orthodontic Treatment | ☐ | ☐ | Had a Bad Dental Experience |
| ☐ | ☐ | Clench / Grind Teeth | ☐ | ☐ | Nervous about Dental Treatment |

❖ **How would you like your smile to look better/different?** _____

_____

**Please check the following if you had or presently have:**

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Cortisone Medicine | ☐ Hepatitis A, B and/or C (Please Specify) | ☐ Psychiatric Care |
| ☐ Allergies - Seasonal | ☐ Diabetes | | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Drug Addiction | ☐ Herpes | ☐ Rheumatism |
| ☐ Arthritis/Gout | ☐ Emphysema | ☐ High Cholesterol | ☐ Shortness of Breath |
| ☐ Artificial Heart Value | ☐ Epilepsy or Seizures | ☐ High Blood Pressure | ☐ Sickle Cell-Anemia |
| ☐ Artificial Joints/Hips | ☐ Excessive Thirst | ☐ HIV+ | ☐ Sinus Trouble |
| ☐ Asthma | ☐ Fainting or Dizziness | ☐ Hypoglycemia | ☐ Steroids |
| ☐ Blood Disease | ☐ Fever Blisters | ☐ Kidney Trouble | ☐ Stroke |
| ☐ Blood Transfusion | ☐ Frequent Cough | ☐ Liver Disease | ☐ Swelling Feet/Hands/Ankles |
| ☐ Bone Cancer | ☐ Glaucoma | ☐ Low Blood Pressure | |
| ☐ Bruise Easily | ☐ Hay Fever | ☐ Lung Disease | ☐ TB |
| ☐ Cancer | ☐ Heart Murmur | ☐ Mitral Valve Prolapse | ☐ Thyroid Disease |
| ☐ Chemo/Radiation | ☐ Heart Pacemaker | ☐ Nervousness | ☐ Ulcers |
| ☐ Chest Pain | ☐ Heart Surgery | ☐ Osteoporosis/-penia | ☐ Venereal Disease |
| ☐ Cold Sores | ☐ Heart Trouble | ☐ Pain in Jaw Joints | ☐ X-Ray or Cobalt TMT |
| ☐ Congenital Heart Lesion | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Yellow Jaundice |

— Are you <u>currently</u> being treated for a medical problem? If yes, please specify _____
_____

— Are you <u>currently</u> taking any pills or medications? If yes, please specify _____
_____

— Have you been hospitalized within the last five years? If yes, for what? _____
_____

**I hereby authorize the dental office to inquire about my credit history through the Credit Bureau of Rochester. Any remaining balance on my account is my responsibility. I agree to pay my balance plus finance charges at the legal rate and reasonable collection costs and/or attorney's fees incurred by the dental office if my balance in not paid.**

**I hereby authorize the dental office to release any medical or other information necessary to process my insurance claim forms.**

**I hereby authorize the dental office administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The above information is accurate to the best of my knowledge.**

**SIGNATURE:_____ DATE:_____**

## Disclaimer

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.
I assign dental benefit payments to be made directly to Full Heart Dentistry from my insurance company.
I give permission for my dentist and her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.
I understand if referral to an outside agency for collections becomes necessary, I agree to pay reasonable collection cost and attorney fees.

SIGNATURE:_____ DATE:_____

## Appointment Reminder

We may call or write to remind you of scheduled appointments and/or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may mail you an appointment reminder on a postcard, and/or leave you a reminder message on your answering machine or with someone who answers your telephone if you are unavailable.

SIGNATURE:_____ DATE:_____

## Patient Consent

I consent to the use or disclosure of my protected health information by Full Heart Dentistry ("the practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the practice.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree with the restrictions that I may request. However, if the practice agrees to a restriction that I request, the restriction is blinding on the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that my practice has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employers or health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment or bills or in the performance of health care operations of the practice. The Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information.

I understand the Notice of Privacy Practices is posted in the waiting room. The practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices by asking the receptionist for one during regular business hours.

_____ _____

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

_____

Date

## Optional Consent

I authorize Full Heart Dentistry to share my health and personal information with the following people. I understand that I do not have to fill this out if I don't want my information shared.

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Limitations, Please Specify: _____

_____

I understand that this consent can be changed or cancelled at any time with a written request to Full Heart Dentistry, but that cancelling it will not affect any information that has already been released.