PRISTINE
Family & Implant Dentistry

# PATIENT INFORMATION

Welcome to Pristine Family and Implant Dentistry. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: ___/___/_____ Sex m / f

First M.L Last

Home address: _____ City: _____ State: _____ Zip: _____

Billing address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

Drivers license #: _____ Social security# _____

Employer/occupation: _____ Bus. Phone# _____

Spouse name: _____ Emergency Phone# _____

Primary dental insurance: _____ Group# _____ Id # _____

Secondary dental insurance: _____ Group # _____ Id # _____

Subscriber's name: _____ Date of birth: ___/___/_____ SS# _____

Name of physician: _____ Date of last visit to physician: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: google / facebook / mailer / others: _____

# DENTAL HEALTH HISTORY

What brings you in today?

Pain (emergency) / examination / implant / cleaning / others

Do you want complete dental care? ..... y / n

Are you apprehensive about dental treatment?

..... y / n

Are you dissatisfied with your smile or appearance of teeth? ..... y / n

Have you had problems with previous dental treatment? ..... y / n

Do you gag easily? ..... y / n

Does food catch between your teeth? ..... y/ n

Have you ever been diagnosed with periodontal disease? ..... y / n

Do your gums bleed easily? ..... y / n

Do your gums feel swollen or tender? ..... y / n

Do you take fluoride supplements? ..... y / n

Are your teeth sensitive? ..... y / n

Hot foods or liquids? ..... y / n

cold foods or liquids? ..... y / n

Sours? ..... y / n

sweets? ..... y / n

Do you prefer to save your teeth? ..... y / n

How often do you brush? 1X day / 2x day / 3x day

How often do you floss? 3X day / 1x day / other

Have you been diagnosed jaw disorder (tmd)? ..... y / n

Does your jaw make clicking/popping noise? ..... y / n

Are you aware of any clenching/grinding? ..... y / n

Does jaw pain affect your quality of life? ..... y / n

Have you ever injured your head or jaw? ..... y / n

Are you a habitual gum chewer or smoker? ..... y /n

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# MEDICAL HEALTH HISTORY

**Premedication required by a physician** **y / n**

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

Local anesthetics ("novocaine" y / n
Penicillin or other antibiotics y / n
Sulfa drugs y / n
Barbiturates, sedatives or sleeping pills y / n
Aspirin, acetaminophen or ibuprofen y / n
Codeine, demerol or other narcitics y / n
Reaction to metals y / n
Latex or rubber dam y / n
Other y / n
Note: _____

**Heart problems** **y / n**

Chest pain y / n
Shortness of breath y / n
Blood pressure problem y / n
Heart murmur y / n
Heart valve problem y / n
Taking heart medication y / n
Rheumatic fever y / n
Pacemaker y / n
Artificial heart valve y / n

**Diabetes** **y / n**

**Type I** **Type II**

Urinate more than 6 times per day y / n
Thirsty or mouth is dry most of the time y / n
Family history of diabetes y / n

**Blood problems** **y / n**

Easy bruising y / n
Frequent nose bleeds y / n
Abnormal bleeding y / n
Blood disease (anemia) y / n
Ever require a blood transfusion y / n

**Allergy problems** **y / n**

Hay fever y / n
Sinus problems y / n
Skin rashes y / n
Taking allergy medication y / n
Asthma y / n

**Bone or joint problems** **y / n**

Arthritis y / n
Back or neck pain y / n
Joint replacement y / n

**Epilepsy or other neurlogcal disease** **y / n**

Fainting spells, seizures or epilepsy y / n
Strokes y / n
Frequent or severe headaches y / n

**Thyroid problems** **y / n**
**Persistent cough or swollen glands** **y / n**
**Cancer/tumor** **y / n**

**Intestinal problems** **y / n**

Ulcers y / n
Weight gain or loss y / n
Special diet y / n
Constipation/diarrhea y / n
Kidney or bladder problems y / n

**Do you drink alcohol?** **y / n**

If so how much?_____

**Do you smoke?** **y / n**

If so how much?_____

Hepatitis, jaundice, or liver trouble y / n
Herpes or other std y / n
Hiv positive / aids y / n
Glaucoma y / n
Do you wear contact lenses y / n

History of head injury ..... y / n
History of alcohol or drug abuse ..... y / n
Tuberculosis or other respiratory disease ..... y / n

**Do you have any disease, condition, or problem not listed previously that you feel we should know about.**
If so, please describe _____

_____

**During the past 12 months have you taken any of the following?**
Antibiotic or sulfa drugs ..... y / n
Anticoagulants (ex. Coumadin) ..... y / n
High blood pressure medication ..... y / n
Tranquilizers ..... y / n
Insulin, orinase, or similar drug ..... y / n
Aspirin ..... y / n
Digitalis or drugs for heart trouble y / n
Nitroglycerin y / n
Cortisone (steroid) y / n
Natural remedies ..... y / n
Non-prescription drug supplements ..... y / n
Other ..... y / n

**Women**
Are you taking contraceptives or other hormones? ..... y / n
Are you pregnant? ..... y / n
If so, expected delivery date_____
Are you nursing? ..... y / n
Have you reached menopause? ..... y / n
If so, do you have any symptoms? ..... y / n

_____

_____

Patient/parent signature

_____

Date _____

Dentists initials _____

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance portability & Accountability Act of 1996 (HIPPA), I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of healthcare providers who may be Involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my healthcare services.

Conduct normal health care operations such as assessment and improvement activities.

I have been informed of my healthcare provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my healthcare provider has the right to change the Notice of Privacy Practices and I may contact the office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Signature: _____ Date: _____

Dependent family members also covered by the acknowledgement

_____

Additional Disclosure Authority: (Parent/Guardian)

Name: _____ Relationship: _____

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# FINANCIAL POLICY AGREEMENT

Payment Terms:

1. 2 Payment Option: We offer a two-payment option for Crowns, Bridges and Dentures. We ask that you pay one-half of your co-payment at the first appointment and the remaining balance is due at the second appointment. Implants require full payment the day we place the implant.

2. Care Credit: We offer our patients, upon approval, a financing program with no down payment. Care Credit provides several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application

**PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED**

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. We accept cash, check, ATM cards and major credit cards.

Patient Signature: _____ Date: _____