TWINHICKORYDENTAL

Today's date: _____ Nick Name: _____

Name (First, M, Last): _____
Birthdate: _____ SSN: _____ Marital Status: _____Sex: ☐M ☐F
Mailing Address with Zip-code: _____

_____
Cell Phone: _____Home Phone: _____Work Phone:_____
Email Address: _____
Patient's Spouse/Parent's Name: _____ DOB: _____
Relationship to Patient: _____Contact phone: _____
Address (if different than patient): _____
Whom may we thank for referring you? _____

ACCOUNT Responsible Person: _____DOB: _____
Address: _____
Cell phone: _____ Home/work phone: _____

DENTAL Insurance Information (not Medical):
Dental Insurance name: _____DENTAL Insurance ID: _____
Subscriber's name: _____SSN: _____
Subscriber's DOB: _____ Relationship to Patient: _____
Subscriber's Employer: _____Work Phone: _____
Employer's Address: _____
Group Name on card: _____ Group no: _____

Do you have any additional or secondary Insurance? _____
Dental Insurance name: _____ DENTAL Insurance ID: _____
Subscriber's name: _____SSN: _____
Subscriber's DOB: _____ Relationship to Patient: _____
Subscriber's Employer: _____Work Phone: _____
Employer's Address: _____
Group Name on card: _____ Group no: _____

Medical Insurance name: _____ID: _____

Person to Contact in case of **EMERGENCY:**
Name: _____Relationship: _____
Address: _____
Cell phone: _____Home: _____ Work: _____

☞
PATIENT'S/ GUARDIAN'S Signature _____ DATE: _____

TWINHICKORYDENTAL

Dental History Form

Patient Name: _____ DOB: _____

1). REASON for today's visit: _____
_____

2). Previous Dentist/Practice Name: _____
_____
Contact number: _____

Please share the following dates:
Last dental cleaning: _____
Last oral cancer screening: _____
Last set of x-rays:_____

3). Your dental checkup frequency: ☐ Twice/year, ☐ Once/year, ☐ Only if problem exists, ☐ Never

4). Do you **smoke** or use **chewing tobacco**? _____
How much? _____
For how long? _____

5). How often you brush? _____
Do you Floss? ☐ Yes ☐ No

6). Please check any of the following problem that apply to you:

- ☐ Tooth Pain/discomfort: If Yes, where? _____
- ☐ Sensitivity (hot or cold or sweet)
- ☐ Broken tooth or fillings
- ☐ Loose, Tipped or shifted teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Bad breath or bad taste in your mouth
- ☐ Mouth Ulcers or cold sores
- ☐ Frequent Headaches

7). Jaws related concerns (TMJ/TMD):

- ☐ Pain (joint, ear, side of face)
- ☐ Clicking
- ☐ Clenching/Grinding of your teeth,
- ☐ Difficulty opening and closing,
- ☐ Difficulty in chewing

8). Have you ever had any difficult extraction in the past? ☐ YES ☐ NO

9). Have you ever had any prolonged bleeding following extraction? ☐ YES ☐ NO

10). Do you have or have you ever had any of the following treatments?

- ☐ Braces/orthodontic treatment
- ☐ Gum treatment/Gum surgery
- ☐ Night/Occlusal Guard
- ☐ Complete Denture
- ☐ Partial Denture

11). What is the most important thing to you about your future smile and dental health? _____
_____
_____

12). Are you satisfied with the appearance of your teeth? _____If NO, How would you like to change the appearance of your teeth?

- ☐ Make my teeth whiter
- ☐ Make my teeth straight
- ☐ Close spaces
- ☐ Replace Metal Fillings with tooth colored
- ☐ Repair chipped teeth
- ☐ Replace missing tooth
- ☐ Replace old crowns that do not match
- ☐ Have a Smile Make Over (Traditional Veneers or Lumineers)

13). If you could whiten your teeth for an affordable rate, would you? _____
_____

14). If you could straighten your teeth for an affordable rate, would you? _____
_____

☞ **PATIENT'S/ GUARDIAN'S Signature** _____ DATE: _____

Clear Form

TWINHICKORYDENTAL

PATIENT MEDICAL HISTORY

Patient's Name: _____ Gender: ☐ M ☐ F

Physician Name: _____ Phone: _____

Physician's Address: _____

Last Date of Exam: _____ Reason of Exam: _____

Name of Parent (If Minor): _____

1). Are you currently under the care of a physician? _____ If yes, Please explain: _____

_____

2). Have you been admitted to a hospital or needed emergency care during the past two years? _____

If yes, Please explain: _____

3). Do you need **ANTIBIOTIC** medications 1 hour before dental treatment? ☐ YES ☐ NO

4). Are there any change in your health in the past year? ☐ YES ☐ NO If yes, Please explain: _____

_____

5). Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates ?

☐ YES ☐ NO, If YES, Which One and How long?_____

6). Are your **ALLERGIC TO** or Have you had **any unusual REACTION** to the following? ☐ No Drug Allergies

☐ Penicillin ☐ Amoxicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Clindamycin

☐ Iodine ☐ Latex ☐ Any Metal ☐ Fluoride ☐ Novocain ☐ Local Anesthetics

☐ Other (please list) _____

7). Any history of Anaphylaxis ? _____

8). Have you ever been diagnosed or treated for any of the following conditions?

	YES	NO		YES	NO
Anemia	☐	☐	Diabetes (Sugar problem)	☐	☐
Sickle Cell Anemia	☐	☐	Frequent Hypoglycemia (Low Sugar)	☐	☐
Leukemia or Blood Cancer	☐	☐	High Blood Pressure (Hypertension)	☐	☐
Other Cancer or Tumor	☐	☐	Low Blood Pressure Problem	☐	☐
Chemotherapy	☐	☐	Kidney Disease or Dialysis treatment	☐	☐
Radiation Treatment	☐	☐	Liver disease, Hepatitis C/B	☐	☐
Bleeding Disorder	☐	☐	Liver Failure or Cirrhosis	☐	☐
Excessive Bleeding	☐	☐	Liver or Kidney Transplant	☐	☐
Bruise Easily	☐	☐	Short of Breath or Short Winded	☐	☐
Arthritis / Gout	☐	☐	Asthma	☐	☐
Bone Disease / Osteoporosis	☐	☐	Lung Disease like COPD, Emphysema or Bronchitis	☐	☐
Chronic Inflammatory Disorders like Lupus, Rheumatoid arthritis etc.	☐	☐	Stomach Problems like Acid reflux, GERD	☐	☐
Chronic Steroid (Prednisone) Treatment?	☐	☐	Stomach Ulcers or Peptic Ulcers	☐	☐

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	YES	NO		YES	NO
Hip or Knee Joint Replacement	☐	☐	Thyroid Disorder (Hyper or Hypo)	☐	☐
Sinus Problems	☐	☐	Glaucoma	☐	☐
Depression or Bipolar disorder	☐	☐	Tuberculosis	☐	☐
Nervousness or Anxiety	☐	☐	Herpes (Fever Blisters) / Cold Sores	☐	☐
Other Mental Health Problem	☐	☐	Hives or Hay Fever	☐	☐
Convulsions / Epilepsy / Seizure	☐	☐	AIDS or HIV Positive	☐	☐
Recreational Drug use (Cocaine, Marijuana or Heroin etc.)	☐	☐	Sexually Transmitted Disease (like Gonorrhea or syphilis etc.)	☐	☐

HEART Problems:	YES	NO		YES	NO
Angina (Chest Pain)	☐	☐	Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐	Other Heart Valve Problems?	☐	☐
Rheumatic Heart Disease	☐	☐	Artificial Heart Valve	☐	☐
Heart Attack? How many times?	☐	☐	Pacemaker or Defibrillator or ICD	☐	☐
Heart Failure?	☐	☐	Bypass Surgery (Open heart Surgery	☐	☐
Stroke?	☐	☐	Syncope	☐	☐
Dizziness, Lightheadedness or Fainting	☐	☐			

9). If needed, please explain any of the above answers in details. Or Have you ever had any serious illness not listed above? _____

_____

_____

_____

_____

WOMAN ONLY:

1). Do you take birth control pills? ☐ YES ☐ NO
2). Do you take any hormone pills? ☐ YES ☐ NO
3). Are you or do you think you are pregnant? ☐ YES ☐ NO
If yes, what is due date? _____
4). Currently, nursing (breast feeding) your baby ? ☐ YES ☐ NO

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

☞ Patient's or Guardian's Signature: _____ Date: _____

TWINHICKORYDENTAL

MEDICATIONS

Patient's Name: _____DOB: _____

Physician's full Name: _____

Physician's Phone No: _____ Fax No: _____

Please list all PRESCRIPTION or OVER THE COUNTER medications you are currently taking. This included vitamins, herbal, dietary supplements and sexual enhancement drugs. Include the DOSAGE, Frequency taken and the REASON for taking medications.

DRUG NAME (BRAND & GENERIC)	DOSE	FREQUENCY	REASON OF TAKING

PATIENT'S/ GUARDIAN'S Signature _____ DATE: _____

TWINHICKORYDENTAL

Informed Consent of Dental Treatment

Dentistry to be performed: I, hereby, grant consent for Dr. Patel and/or staff member in charge of my care to obtain all necessary diagnostic information, such as radiographs (x-ray), as needed in order to reach a diagnosis of my condition. I understand that the doctor will visually examine my mouth, teeth and gum. I will be asked to review all benefits, pertinent risks and alternatives to proposed treatment. I consent to start treatment.

Please Initial: _____

Change During/After Treatment: I understand that during treatment it may be necessary to change or add procedures because of conditions, which were not evident during the initial examination or in x-ray. If such change or addition should occur the doctor will discuss the benefits, pertinent risks and alternatives in which tooth cannot be restored and need to be pulled. I consent for change during or after treatment is started.

Please Initial: _____

Anesthesia or Medications: I understand that I may require injections of local anesthesia, the use of nitrous oxide, prescribed antibiotics, antianxiety medications and/or analgesic medications. These medications can cause untoward or unusual or allergic reactions including, but not limited to: nausea, vomiting, bruising, hematoma, itching, tissue irritation, prolonged muscle soreness, temporary or rarely permanent numbness, accidental tongue or lip biting while numb, drowsiness, cardiac stimulation or respiratory problems. I understand that occasionally needles break which may require surgical retrieval with oral and/or general surgeon. If I suffer any of these symptoms, I will contact the doctor immediately for evaluation of my symptoms. I acknowledge that I have been informed of the risk and possible operation proposed and do authorize the doctor to proceed.

Please Initial: _____

Basic Restorations (Fillings): The Twin Hickory Dental does not use or offer the amalgam (metal/silver) material for restorations. I understand that if my insurance carrier provides lesser alternative benefits for amalgam (metal/silver) restorations, I will be responsible for the difference between the silver amalgam to the composite resin restoration (tooth colored material) fee. I understand if my cavity is very deep or close to my tooth nerve, my tooth may need Root Canal Treatment in future after filling. I acknowledge that I have been informed of the risk, benefit, and alternative of the proposed procedure and do authorize the doctor to proceed.

Please Initial: _____

☞ Signature of Patient (or Parent/Guardian if Minor): _____

Patient's Name: _____ Date: _____

TWINHICKORYDENTAL

Financial Policies and Dental Insurance Information

Thank you for choosing our office as your dental health care provider. Our primary responsibility is providing the highest quality dental care for you and your dependents. Part of our commitment is your understanding and responsibility for the payment of your account balance.

Dental Insurance: Insurance is a contract between you, your employer, and the insurance company. We have no control over your coverage and benefits. Our office does not guarantee that your insurance company will pay for the treatment you receive. We will be happy to file or charge to your insurance as a courtesy to you. However, you will be responsible for your account balance for your deductible, co-payment and insurance underpayments. Please know that your estimated payment with deductible will be due at the time the service. If your claim is denied or the treatment is downgraded and/or alternative benefits are paid by your insurance company, you will be responsible for the remaining balance amount left on the account at that time.

_____ **(Please Initial)**

For some dental procedures, which includes cosmetic dentistry and orthodontic services (Veneers, Lumineers, Six Month Smiles Cosmetic Braces, Invisalign, Clear Correct and/or any kind of aligner or braces treatment), you will be charged office fee regardless of what your insurance pays or fees are.

For an **emergency visit**, 100% is due at the time of service.

For Minors: The adult accompanying the minor is responsible for the payment. For unaccompanied minors, non-emergency treatment will be denied.

Monthly Payments: If you need to make long-term payment, we can offer depending on each case. We ask your credit card on file for monthly payments option.

Accepted methods of payment: Cash, personal check, credit card (Visa, MasterCard, American Express or Discover), and CareCredit.

Cancellation & Broken appointments: There will be a **$50.00 per hour** charge for a broken appointment if two business days' notice is not given**.** You will receive reminder email, text and/or telephone call as a courtesy for your upcoming appointment. However, you are ultimately responsible for remembering your scheduled appointment.

I authorize and release information and payment of my dental insurance to the dentist. I agree to accept responsibility for payment of my bill including deductible, co-pay and/or non-covered services. I understand that in the event my account balance becomes 60 days overdue from the day of service, my account will incur $35 delinquent fee and a 1.5% monthly (18% Annual) finance charge on the unpaid balance. Furthermore, my account will be forwarded to collection agencies and I will be responsible for attorney's fees, court costs and any other charges incurred to collect this account.

I have read this ***Financial Policy***. I understand and agree to the terms of the ***Financial Policy of Twin Hickory Dental***. ***Picture ID is also required with your signature.***

Patient/Guardian Signature: _____ Date: _____

Patient's Name: _____

TWINHICKORYDENTAL

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain an acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

I, _____(Print Name), have read a copy of this office's notice of privacy practices.

Patient Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify): _____

Prepared by: _____Signature: _____

Authorization for Release of Protected Health Information & Dental Records

I, _____ (Patient name) give permission to the following people to access my dental records. This authorization will remain in effect until I revoked in writing again.

Patient Signature: _____ Date: _____

1). Name: _____ Relationship:_____

Phone Number: _____

2). Name: _____ Relationship:_____

Phone Number: _____

3). Name: _____ Relationship:_____

Phone Number: _____