DENTAL WISE
DENTAL HISTORY

Patient Name_____Nickname_____Age_____

Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist_____How long have you been a patient? _____ Months/Years

Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___

Date of most recent treatment (other than a cleaning) ___/___/___ I routinely see my dentist every □3 mo. □4 mo. □6 mo. □12 mo. □Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	O	O
2. Have you had an unfavorable dental experience?_____	O	O
3. Have you ever had complications from past dental treatment? _____	O	O
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	O	O
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	O	O
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?_____	O	O
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?_____	O	O
8. Have you ever been treated for gum disease, had scaling and root planing, or told you have lost bone around your teeth?	O	O
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	O	O
10. Is there anyone with a history of periodontal disease in your family? _____	O	O
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	O	O
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?____	O	O
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	O	O
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years? _____	O	O
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	O	O
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	O	O
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	O	O
18. Do you have grooves or notches on your teeth near the gum line? _____	O	O
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	O	O
20. Do you frequently get food caught between any teeth? _____	O	O
BITE AND JAW JOINT	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	O	O
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	O	O
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____	O	O
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	O	O
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	O	O
26. Are your teeth developing spaces or becoming more loose?_____	O	O
27. Do you have trouble finding your bite, need to squeeze/tap your teeth together, or shift your jaw to make your teeth fit together?	O	O
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____	O	O
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	O	O
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	O	O
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with headaches or an awareness of your teeth?	O	O
32. Do you wear or have you ever worn a bite appliance? _____	O	O
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?_____	O	O
34. Have you ever bleached (whitened) your teeth?_____	O	O
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____	O	O
36. Have you been disappointed with the appearance of previous dental work?_____	O	O

Patient's Signature _____ Date_____

Doctor's Signature _____Date_____

Patient Information

Patient name _____ **DOB** ____/____/____ **Age**_____ **SS#** ____-____-_____
Address _____ **City**_____ **State** _____ **Zip**_____
Phone #(____)_____-_____ **Email**_____**Employer**_____
Dental Insurance Co._____ **ID#**_____**Group #**_____
How did you hear about us?_____**Reason for today's visit?**_____

Medical History

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease)_	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

ASA _____ **(1-6)**

DENTAL WISE

OFFICE APPOINTMENT POLICY

We strive to provide dental care to all in a timely manner. In order to do so, we highly value our scheduled appointment times.

CONFIRMATION: As a curtesy to our patients, a reminder text and call will be made prior to confirm appointments, we encourage our patients to confirm their appointments or make needed changes in a timely manner. PLEASE RESPOND TO OUR CONFIRMATION REQUEST.

RESCHEDULE: We encourage our patients to give at LEAST one business day notice prior to rescheduling. If no notice is given, the patient will be assessed a $58 fee/per hour for each "last minute cancellation" – Patients who provide a 24 hour business day notice WILL NOT be assessed a fee and will be able to reschedule appointments without penalty.

LATE ARRIVAL: We encourage our patients to arrive 10 minutes prior to their scheduled appointment time. We cannot guarantee an assigned appointment time for late patients, and after 15minutes your appointment will be defaulted, you will be charged and you will need to reschedule

"NO SHOW": Patients with confirmed appointments who DO NOT COME IN for their assigned time are considered a "NO SHOW" patient. Two "NO SHOWS" result in the loss of any future appointments. In addition, a $58 fee will be assessed to the patients account for each "NO SHOW". (Emergency Services will still be provided on a first-come first served basis.)

I understand and agree to the Office Appointment Policy: Name *(printed)*:_____

Signature: _____ Date: _____

DENTALWISE

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM.

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claim.

Patient Name:_____ **Date:** _____
How do you want to be addressed when summoned from the reception area:
□ **First Name Only** □ **Proper Surname** □ **Other**

Please list any other parties who are actively involved in your health care and who can have access to your health information. (This includes step parents, grandparents and any care takers who can have access to this patient's records).
Name: _____ **Relationship:** _____
Name: _____**Relationship:** _____

I authorize contact from this office to confirm my appointments, treatment & billing information via:
□ **Cell Phone Confirmation**
□ **Text Message to my Cell Phone**
□ **Home Phone Confirmation**
□ **Email Confirmation**
□ **Work Phone Confirmation**
□ **Any of the Above**

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:
□ **Phone Message**
□ **Text Message**
□ **Email**
□ **Any of the Above**
□ **None of the** (opt out)

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASED SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____

Printed name of Patient — Signature of Patient/Guardian of Patient

_____

Legal Representative/Guardian — Relationship of Legal Representative/Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

□ It was emergency treatment
□ I could not communicate with the patient
□ The patient refused to sign
□ The patient was unable to sign because_____
□ The patient refused to sign _____

Signature of Privacy Officer_____