BISSELL DENTAL GROUP NEW PATIENT INFORMATION FORM

Welcome to our Practice

We appreciate the confidence you have placed with us to provide your dental care. Please take a few minutes to fill out these forms as completely as you can. The information you provide will remain confidential and help assist us in your dental treatment. If you have any questions we'll be glad to help you.

Patient Information **Today's Date:** _____

Patient Name: _____ Nickname: _____

SS#_____ DOB: __/__/____ Age: _____ Sex: M/F Employer: _____

Street Address: _____City:_____ State: ____ Zip: _____

Billing Address: _____City:_____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Primary Insurance Company Name: _____ Group# _____

Policy Holder Name: _____ SS/ID#_____ DOB: __/___/____

Insurance Company Address: _____

Insurance Company Phone#_____ Policy Holder's Employer: _____

Secondary Insurance Company Name: _____ Group# _____

Policy Holder Name: _____ SS/ID#_____ DOB: ___/___/___

Insurance Company Address: _____

Insurance Company Phone#_____ Policy Holder's Employer: _____

Medical History

Patient Name: _____ Nickname: _____ Age: _____
Name of Physician/and their specialty: _____
Most recent physical exam: _____ Purpose_____
What is your estimate of your general health? _____excellent ____ good ____ fair ____ poor

Do you or have you ever had: **Yes/No**

1. Dental related Illness or injury __/__
   If yes for what and when: **____**
2. Allergic reaction to: __/__
   __Aspirin, IBU, Acetaminophen
   __Pain Medicine: **_____**
   __Penicillin
   __Erythromycin
   __Tetracycline
   __Sulfa
   __Dental Anesthetics
   __Fluoride
   __Metals (nickel, Gold, Silver, etc...)
   __latex
   __other **Explain:** _____
3. Heart Problems __/__
   If yes, what and when? _____
4. Infective endocarditic __/__
5. Artificial heart valve __/__
   If yes, when? _____
6. Pacemaker or defibrillator
7. Artificial Joints (HIP, KNEE, Etc…) __/__
   If yes, when? _____
8. Rheumatic fever (heart murmur) __/__
9. High blood pressure __/__
10. Low blood pressure __/__
11. Stroke __/__
12. Anemia __/__
13. Prolonged bleeding
    Due to **blood thinners** __/__
14. Emphysema or COPD __/__
15. Tuberculosis __/__
16. Asthma __/__
17. Breathing or sleeping disorder __/__
18. Kidney disease __/__
    If on Dialysis, how often? _____
19. Liver disease __/__
20. Jaundice __/__
21. Thyroid/Graves Disease __/__
22. Hormone Deficiency __/__
23. High Cholesterol __/__
24. Diabetes **(type:)** __/__
25. Stomach ulcers __/__
26. Osteoporosis __/__
27. Arthritis __/__
28. Glaucoma __/__
29. Head or neck injury __/__
30. Epilepsy __/__
31. ADD or ADHD __/__
32. Cold Sores __/__
33. STD __/__
34. Hepatitis **(type)** __/__
35. Tumor/abnormal growth __/__
36. Radiation therapy __/__
37. Chemotherapy __/__
38. Depression __/__
39. Alcohol/ Drug abuse __/__
40. Migraines or headaches __/__

ARE YOU?

1. Being treated for illness __/__
   If yes, Explain: _____
2. Having Fever, chills, cold symptoms __/__
3. On a weight management program __/__
4. Taking dietary supplements __/__
5. Often fatigue __/__
6. Smoker __/__

FEMALE:

1. Taking birth control __/__
2. Pregnant __/__

MALE

1. Prostate disorders __/__

Describe any current medical treatment that may possibly affect your dental treatment. (i.e. **PRE-MED**)

_____
_____

<u>PLEASE LIST ALL</u> medications, supplements and/or vitamins (use back if more space is needed)

_____ _____ _____
_____ _____ _____
_____ _____ _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS.

I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history.

Patient/Responsible Party: _____ **Date**_____

Dental History

How would you rate the current condition of your mouth? ____excellent ____ good ____fair ____poor
Name of previous dentist _____
How long had you been a patient there _____ months/years
Date of most recent dental exam_____/_____/_____
Date of most recent x-rays _____/_____/_____
Date of most recent dental treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ____3mos. ____4 mos. ____6mos. ____12 mos. ____ not routinely
What is your immediate concern? _____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES/ NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) _____ __/__
2. Have you ever had an unfavorable dental experience? __/__
3. Have you ever had complications from past dental treatment? __/__
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? __/__
5. Did you ever have braces, Orthodontic treatment, or had your bite adjusted? __/__
6. Have you had any teeth removed? __/__

GUM AND BONE

1. Do your gums ever bleed or are they tender when brushing and flossing? __/__
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? __/__
3. Have you ever noticed an unpleasant taste or odor in your mouth? __/__
4. Is there anyone with a history of periodontal disease in your family? __/__
5. Have you ever experienced gum recession? __/__
6. Have you ever had your teeth become loose on their own? (without an injury) __/__
7. Have you experienced a burning sensation in your mouth? __/__

TOOTH STRUCTURE

1. Have you had any cavities with-in the past three years? __/__
2. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? __/__
3. Do you feel or notice any holes? (pitting, craters)on the biting surface of your teeth? __/__
4. Are any teeth sensitive to hot, cold, sweets, biting, do you avoid brushing any part of your mouth? __/__
5. Do you have any roves or notches on your teeth near the gum line? __/__
6. Have you ever broken teeth, chipped teeth, had a toothache or cracked filling? __/__
7. Do you frequently get food caught between any teeth? __/__

BITE AND JAW JOINT

1. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? __/__
2. Do you feel like your lower jaw is being pushed back when you bite your teeth together? __/__
3. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars or any other foods? __/__
4. Have your teeth changed in the last five years, become shorter, thinner or worn? __/__
5. Are your teeth crowding or developing spaces? __/__
6. Do you have more than one bite, and squeeze to make your teeth fit together? __/__
7. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? __/__
8. Do you clench your teeth in the daytime or make them sore? __/__
9. Do you have any problems with sleep or wake up with an awareness of your teeth? __/__
10. Do you wear or have you ever worn a bite appliance? __/__

SMILE CHARACTERISTICS

1. Is there anything about the appearance of your teeth that you would like to change? __/__
2. Have you ever whitened (bleached) your teeth? __/__
3. Have you felt uncomfortable or self conscious about the appearance of your teeth? __/__
4. Have you been disappointed with the appearance of your previous dental work? __/__

Bissell Dental Group Office Policies/ Financial Arrangements

Thank you for choosing our office for your dental needs. We realize that every person has a different financial situation. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and will allow you to enjoy a healthy, beautiful smile while respecting your budget at the same time. (Please let us know if you have any questions.)

Payment Options:

Full Treatment Plan Payment Discount- We offer a 5% discount if your treatment plan is paid in full at the time of service by cash or check.

Pay As You Go- If you have no dental insurance please pay the full amount at the time of service. If you do have dental insurance please pay your estimated co-pay at the time of service. (Unless other payment arrangements have been made)

Credit Card Payment Plan- This allows you to make payments for an agreed upon period of time. Typically, we will divide your balance over a three or four month period. The credit card of your choice will be run monthly or weekly on the day of your choice.

Third Party Payment Plans: Bissell Dental Group does accept Care Credit. This plan allows you to make payments through the third party creditor. Care Credit offers interest free, finance free loans for dental and medical bills. If you are interested in this plan please let us know, and we will assist you in setting up your Care Credit account.

I understand and agree that all services rendered to me, my dependants or others assigned by me to my account are charged directly to me. I further understand that I am personally responsible for payment. If the fees for the professional services are not paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. A 1.5% monthly late/past due fee will be added to any accounts 90 days or more past due. Any returned checks will be subject to a $25 bank fee as well as any additional charges incurred to collect these funds. We do request 24 hours notice to cancel or reschedule appointments. Appointments not cancelled with-in 24 hours notice will be subject to a $50 per hour cancelation fee.

Patient/Responsible Party: _____ Date: _____

HIPPA Acknowledgement of receipt of notice of privacy practices. You may refuse to sign this acknowledgement. (Please let us know if you would like a copy of the privacy policy)

I, _____ have receive a copy of the offices Notice of Privacy practices.

Signature_____ Date: _____