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: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Your Email Address: _____

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 have or have you ever had: Yes/ No

1. hospitalization for illness or injury __/__
2. an allergic reaction to:
__ aspirin, ibuprofen, acetaminophen, codeine
__ penicillin
__ erythromycin
__ tetracycline
__ sulfa
__ local anesthetic
__ fluoride
__ metals (nickel, gold, silver_____)
__ latex
__ other
3. heart problems/cardiac stent with-in last 6 mos. __/__
4. history of infective endocarditis __/__
5. artificial heart valve, repaired heart defect __/__
6. pacemaker or implantable defibrillator __/__
7. artificial prosthesis (heart valve or joint) __/__
8. 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 __/__
13. emphysema, shortness of breath, sarcoidosis __/__
14. tuberculosis, measles, chicken pox __/__
15.asthma __/__
16. breathing or sleep problems (apnea, snoring) __/__
17. kidney disease __/__
18. liver disease __/__
19. jaundice __/__
20. thyroid/ parathyroid disease, calcium deficient __/__
21. hormone deficiency __/__
22. high cholesterol or taking statin drugs __/__
23. diabetes (HbA1c=_____) __/__
24. stomach or duodenal ulcer __/__
25. digestive disorders (celiac, gastric reflux) __/__

Yes/No

26. osteoporosis/osteopenia __/__
27. arthritis, rheumatoid arthritis, lupus __/__
28. glaucoma __/__
29. contact lenses __/__
30. head or neck injuries __/__
31. epilepsy, convulsions (seizures) __/__
32. neurologic disorders (ADD/ADHD) __/__
33. viral infections/ cold sores __/__
34. any lumps or swelling in mouth __/__
35. hives, skin rash, hay fever __/__
36. STI/ STD __/__
37. hepatitis (type____) __/__
38. HIV/ AIDS __/__
39.tumor/ abnormal growth __/__
40. radiation therapy __/__
41.chemotherapy/immunosuppressive __/__
42. emotional problems __/__
43. psychiatric treatment __/__
44. antidepressant medication __/__
45. alcohol/ street drug use __/__

Are You:

46. presently being treated for illness __/__
47. aware of change in your health over the last 24 hours (i.e. fever, chills, cold,) __/__
48.taking meds for weight management __/__
49. taking dietary supplements __/__
50. often exhausted or fatigued __/__
51. experiencing frequent headaches __/__
52. smoker/previously smoked __/__
53. considered a touchy person __/__
54. Often unhappy or depressed __/__
55. FEMALE-taking birth control __/__
56. FEMALE- pregnant __/__
57. MALE- prostate disorders __/__

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.)

_____

_____

Please list all medications, supplements and or vitamins taken with-in the last two years

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

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

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

TOOTH STRUCTURE

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

BITE AND JAW JOINT

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

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? __/__
32. Have you ever whitened (bleached) your teeth? __/__
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? __/__
34. 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: _____

Date:

I, _____, authorize the release of my dental radiographs to William Bissell, DDS via email at info@bisselldentalgroup.com.

If you are not digitally capable, please mail them to:

William Bissell, DDS
1660 S. Albion St. #607
Denver, CO 80222
303-757-6139

I also authorize you to release any information pertaining to my dental treatment to Dr. Bissell and his staff including, but not limited to, the date and type of radiographs that were taken at your office. Please contact me should you have any questions.

Thank You,

_____
(Patient's Signature)