WELCOME

1. Patient's Name (first) _____ (middle initial) _____ (last) _____
Driver License _____ Social Security # _____ E-mail _____
Address _____ Apt _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Cell) _____ Birth Date ___/___/___ Age ___
☐ Single ☐ Married ☐ Widower ☐ Divorced
Employer _____ Telephone # _____
Address _____ City _____ State _____ Zip _____
2. Spouse _____ Driver License# _____
Social Security # _____ Birth Date ___/___/___ Telephone # _____
Employer _____ Telephone (Work) _____
3. Responsible Party _____ Driver License# _____
Relation to Patient _____ Social Security # _____
Employer _____ Telephone # _____

4. In Case of Emergency Call _____ Relationship _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Address _____ City _____ State _____ Zip _____

5. Whom can we thank for referring you to our office? _____

6. Insured Patients Only
Insured is ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ other _____
Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date __/__/____ Group # _____
☐ **YES** ☐ **NO Are you covered by a second insurance company?**
If yes, Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date __/__/____ Group # _____

Our office is happy to treat patients with dental insurance. As a courtesy, we will fill out and file all necessary forms; however, you will be asked to pay the deductible and your portion of the charges the day of service. We will gladly estimate your coverage, and we need your patient portion while waiting for payment from your insurance company. Remember, it is just an **ESTIMATE**. If, after 45 days, the insurance company has not paid, the balance will be due in full.

I agree if any default of the above agreement on my part needs legal action, I shall assume all responsibility for interest, and reasonable attorney fees. I have read and understand the above information.

Print Name _____ Signature _____ Date ____/____/____

Assignment of Benefits

I hereby authorize _____ Insurance Company to make payment directly to **Diana Craft D.D.S.** for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on _____.I hereby represent that I am of legal age and legally competent to make this assignment.

Print Name _____ Signature _____ Date ____/____/____

7. Non-Insured Patients

Payment for patients without dental insurance is due in full at the time of service, unless specific arrangements are made in advance.

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____

Our Commitment to You

First:_____
Last:_____

We would like to take this opportunity to thank you for being an important member of our dental practice and to assure you of our continued commitment to excellence in providing dental care for you and your family. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Appointments

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed, often resulting in negative consequences.

- Should any scheduling changes be required, we require at least 24 hours advance notice to avoid a $75.00 cancellation fee.

Courtesy Reminder Calls

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, email and voice mails and text, some of our patients may not receive these reminder calls.

- If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

*Initial*_____

Insurance

We are pleased that you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines.

*Initial*_____

Financial Arrangements

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, credit cards (VISA, MC, American Express and Discover). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion copays at the time treatment is provided.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines.

*Initial*_____

We appreciate your understanding in our efforts to provide you with a positive experience.

Patient Signature: _____ Date_____

Guardian
Signature: _____ Date _____

First:_____
Last:_____

We respect your privacy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

GENERAL RULES

We respect our legal obligation to keep health information that identifies you private. The law obligates us to give you notice of our privacy practices.

We use and disclose health information about you for treatment, payment, and healthcare operations. In most other situations, we will not disclose your health information unless you sign a written authorization form. In some limited situations, the laws allow us or require us to disclose your health information without written authorization.

USES AND DISCLOSURES OF HEALTH INFORMATION

Examples of how we use information for treatment purposes:

- When we set up an appointment for you.
- When our Doctors prescribe medication.
- When our staff assists you with your issues.

We may disclose your dental or health information outside of our office for treatment purposes, for example:

- If we refer you to another Doctor for your dental services.
- If we send dental material to a lab or a technician.
- When we provide a prescription for a medication to a pharmacist.
- When we call you to inform you that your restoration has return from the lab and is ready for delivery.
- When we ask for copies of your dental and health information from another physician you have seen before.

We may use tour dental or health information within our office or disclose your health information outside of our office for payment purposes, for example:

- When a staff member asks you about dental care plans that you may belong to, or about other sources of payment for the services we provide.
- When we prepare bills or claims to send to you or your dental care plan.
- When we process payment by credit card, and when we collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your dental plan.
- When we have to ask a collection agency or attorney to help us with unpaid amounts.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

REQUIRED BY LAW

We may use or disclose your health information when we are required to do so by law. Such uses and disclosures are:

- A state or Federal law that mandates information is reported for a specific purpose.
- Public Health purpose, such as contagious disease reporting. Food and Drug Administration regarding drugs and medical devices.
- Disclosure to authorities for suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as licensing, audits, investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings.
- Disclosure for law enforcement purposes.
- Disclosure to a medical examiner to identify a diseased individual or to determine cause of death.
- Uses or disclosures for health related research.
- Uses or disclosures to prevent serious threat to health or safety.
- Disclosures relation to worker's compensation programs.
- A disclosure to business associates who perform healthcare operations for us and who agree to keep your health information private.

PATIENT RIGHTS REGARDING HEALTH INFORMATION

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment,) payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you requested.
- You have the right to request that we communicate with you about your health and dental information by alternative means. We will accommodate this request if they are reasonable, and an extra fee might be applied. All requests must be in writing with detailed specifications.
- You have the right to look at or get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copies. Primarily, however, you will be able to review or have a copy of your health information within thirty days of asking us. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If we deny your request, we will send you a written explanation. By law, we have a thirty-day extension of time to give you access or photocopies if we send you a written notice of the extension. Your request for access or photocopies of your health information must be in writing.
- You can ask us to amend your health information if you think it is incomplete or incorrect. Your request must be in writing, and it must explain reason for amendment. I f we agree, we will amend the information within sixty days from your written request. By law, we have a thirty-day extension of time to consider a request for amendment if we notify you in writing of the extension.
- You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If such requests are made we may charge you a reasonable, cost-based fee for responding to these additional requests.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new Notice of Privacy Practices will apply to the health information we already have, as well as to such information that we may generate in the future.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complain to Dr. Craft. If you prefer, you can discuss your complaint in person or by phone.

Please sign our Privacy Practice Notice in acknowledgement and understanding of receipt. Copies are available upon request.

Patient or guardian signature: _____ Date: _____

DIANA CRAFT, D.D.S.

Smile Evaluation

First Name: Last Name:

1. Do you like the way your teeth look? Yes ◯ No ◯

   Explain:_____

2. If you could change anything about your smile, what would you change?

   Explain:_____

3. Has dental work made you anxious in the past? Yes ◯ No ◯

   Explain:_____

4. Would you like to discuss anti-anxiety/sedation options for dental treatment? Yes ◯ No ◯

5. Have you ever been told that you snore? Yes ◯ No ◯

6. Do you own a CPAP machine for sleep apnea? Yes ◯ No ◯

   Do you use it? Yes ◯ No ◯