

Welcome to Our Practice

About You:

Patient Name: _____
Last First MI

How do you preferred to be called: _____ male female

Birth date: ___/___/___ Age: _____ SS#: _____ DL#: _____ St: _____

Home Address: _____
Street Address

_____ City State Zip

Home Phone :(____) _____ Work Phone :(____) _____ Cell Phone: (____) _____

Marital Status: Single Married Divorced Separated Widowed

Spouse Name: _____

How Did You Hear About Us? _____

In The Event of Emergency:

Whom should we contact? _____

Relation: _____

Home Phone :(____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Responsible Party: same as above: If different fill below:

Name: _____
Last First MI

Birth date: ___/___/___ Age: _____ SS#: _____ DL#: _____ St: _____

Mailing Address: _____
Street Address

_____ City State Zip

Home Phone :(____) _____ Work Phone :(____) _____ Cell Phone: (____) _____

Primary Dental Insurance Information:

Company Name: _____

Address: _____

Phone #: _____ Insured's ID: _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___ SS#: _____

Employer: _____ Group/Plan #: _____

Dental Information:

Reason for today's visit: _____

Are you in Pain? Yes No How Long? _____

Do you require pre-medication? Yes No Don't know

Previous Dentist: _____ Last Dental Visit: _____

Reason for last dental visit: _____

Medical History: circle all that applies

Heart problems

Low blood pressure

Nervous problems

AIDS or HIV positive

Allergic to Codeine

Allergic to Sulfa

Asthma

Epilepsy

Hepatitis

Hypoglycemia

Malignances

Mumps

Rheumatic fever

Sinus problems

Venereal disease

Taking Birth Control Pills

High blood pressure

Taking blood pressure medication

Pregnant

Allergies to Penicillin

Allergies to Codeine

Arthritis

Diabetes

Excessive bleeding

Herpes

Hypo or Hyperthyroidism

Measles

Psychiatric care

Scarlet fever

Stroke

Radiation treatments

Other questions:

Doctor's name: _____

Doctor's phone #: _____

Pharmacy Name: _____

Pharmacy phone #: _____

Other Allergies: _____

Current Medications: _____

Other: _____

- If I have dental insurance, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am responsible for any balance not paid by my insurance company.
- Payment is required in full for all services rendered at the time of visit, unless other arrangements have been made by the business manager.
- The above information was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I provided.
- I have received a copy to **The Notice of Privacy Practice** and I have been provided an opportunity to review it. I understand that I may ask any questions regarding this notice and can receive a copy upon my request.

Signature of Responsible Party/Patient _____ Date: _____

GENERAL CONSENT FOR DENTAL TREATMENT

We are required to obtain your consent for the proposed dental treatment or oral surgery. Please read this form carefully, and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I hereby authorize and direct B.R. Dental Care and Dr. Suadi or Dr. Biggio to perform upon me or my child, _____, the following dental treatment or oral surgical procedures including the necessary or advisable local anesthesia, radiographs, or diagnostic aids.

In general terms, the dental procedures may include one or a number of the following:

- Cleaning of teeth and application of topical fluoride
- Treatment of periodontal disease with deep cleaning, gum surgery, and bone/soft tissue grafting
- Application of sealants to the grooves of teeth
- Treatment of diseased or injured teeth with dental restorations, either amalgam (silver) or composite (white)
- Stainless steel crowns for children, which are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities
- The replacement of missing teeth with a dental prosthesis (crowns, bridges, partial/complete dentures etc.)
- Extraction (removal) of one or more teeth that cannot be saved
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of overlapped teeth and/or developmental abnormalities
- The use of sedative medications and/or nitrous oxide to control apprehension and anxiety

I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any, along with their advantages and disadvantages have been explained to me. I am advised that good results are expected; however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I fully understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my or my child's health, once treatment has begun.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medication, and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance and hospitalization.

I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination. The most common being the need for root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time I choose to terminate. Such termination of consent must be in writing.

Date

Patient/Parent/Guardian Signature

Witness