PATIENT INFORMATION

Ruth Ann D'Arco, DDS
Carmen D. Vaughn, DMD

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Preferred name: _____ Marital Status: _____ Spouse's name: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work#: _____ Email: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of your previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Dental Insurance Phone #: _____

Subscriber's Name: _____ Date of Birth: _____ SS# _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐

	Yes	No
Are you satisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
How often do you brush?		
How often do you floss?		
Does your jaw make noise?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
High-Blood pressure problems	☐	☐
Low-Blood pressure problems	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Mitral valve prolapse	☐	☐
Stents	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement	☐	☐
Osteoporosis	☐	☐
Any medical surgeries in last 6 weeks	☐	☐
Any medical surgeries where rods/pins/plates/screws were placed	☐	☐
Premedications required by physician	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?	**Yes**	**No**
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other _____		

List current medications: _____

_____

_____ Date: _____

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke or use any tobacco products?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

During the past 12 months, have you taken any of the following?	**Yes**	**No**
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Any treatment for Osteoporosis	☐	☐
Other _____		

_____

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? _____		

_____

Patient/Parent Signature: _____

Dentist Initial: _____

Notes: _____

_____

Belair Dental Associates

Financial Policy

We would like to take this opportunity to welcome you to our office and assure you that we will do our best to provide you with the most comprehensive dental care possible.

If you carry insurance, we will be glad to help you obtain the appropriate benefits from your insurance carrier and we will file your insurance as a courtesy to you.

All payments are due at the time services are rendered unless prior arrangements have been made. We accept cash, check, Visa, MasterCard, Discover, and American Express. We also offer Care Credit which offers payment arrangements with approved credit.

Portions of the bill not paid by the insurance company are to be paid by the patient. It is our office policy to wait a maximum of 60 days for all insurance payments. If in 60 days we have not received the insurance payment, you will then become responsible for the entire balance. Any account that goes over 60 days will have an interest charge of 1.5 % added, including those still pending insurance payments. Once your insurance company has made payment, you may then contact our office for reimbursement.

We look forward to working with you!

Patient Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, follow-up and direct my treatment plan among the multiple healthcare providers

  who may be involved in that directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality

  assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change sits Notice of Privacy Practices form time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment tor health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____