# Patient Information Form

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female Birth Date: _____ Social Security #: _____-_____-_____

Address: _____ Phone: (____) ____-_____(home)____
street apt#

_____ Phone: (____) ____-_____(work) ext:__
city state zip

**E-mail:** _____ Phone: (____) ____-_____(cell)_____

Employer Name: _____Occupation: _____

☐ Single ☐ Married ☐ Other Spouse's Name: _____

**Whom may we thank for your referral**? _____

Reason for your visit today._____

Emergency contact/Relationship to patient: _____ Phone Number:_____

## Medical information

Physician's Name: _____Physician's Phone Number_____
Date of last physical: _____

Have you ever had any of the following (please check boxes that apply):

☐ NONE
☐ ACID REFLUX
☐ AIDS/HIV
☐ ALLERGIES (non-seasonal)
☐ ALZHEIMERS/DEMENTIA
☐ ANEMIA
☐ ANGINA
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINT
☐ ASTHMA
☐ BLEEDING PROBLEMS
☐ CANCER
☐ CHEMO/RAD THERAPY
☐ DIABETES
☐ DIZZINESS
☐ DAILY ASPIRIN
☐ DRUG/ALCOHOL ADDICTION
☐ EMPHYSEMA
☐ EPILEPSY, SEIZURES
☐ FAINTING
☐ HEADACHES
☐ HEART ATTACK
☐ HEART SURGERY
☐ HEART MURMUR
☐ HEART CONDITIONS
☐ HEPATITIS (A,B,C,D)
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ LATEX ALLERGY
☐ LUNG DISEASE
☐ MITRAL VALVE PROLAPSE
☐ NO EPINPHRINE
☐ OSTEOPOROSIS
☐ PACEMAKER
☐ PSYCHIATRIC CARE
☐ RHEUMATIC FEVER
☐ SINUS PROBLEMS
☐ TOBACCO USER
☐ STROKE
☐ SWOLLEN NECK GLANDS
☐ THYROID PROBLEMS
☐ TUBERCULOSIS, (TB)

Please describe any checked boxes: _____
_____

Has your physician recommended that you take antibiotics prior to dental treatment? ☐ yes ☐ no

Are you allergic to any medications? ☐ yes ☐ no
If so, please list all medications: _____

Are you taking any medications at this time (including daily aspirin)? ☐ yes ☐ no
If so, please **clearly** list all medications: _____
_____

Are you currently pregnant? ☐ yes ☐ no Breastfeeding ☐ yes ☐ no

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication

***Signature: X***_____ ***Date:*** _____

# ***Dental Information***

Why did you leave your previous dentist? _____

When was your last cleaning? _____ Oral Cancer Screening _____ x-rays_____

Name of previous dentist _____ City _____ State _____

What is the most important thing to you about your dental visit today? _____

_____

Have you ever had any problems with past dental treatment? _____

Does dental treatment make you nervous? ☐ yes ☐ moderately ☐ slightly ☐ no
We do believe that anxiety may stop patients from having their dental work done, so please ask about relaxation options for your visit.

Have you ever had gum treatments or seen a periodontist? ☐ yes ☐ no

Have you ever had any allergic reactions with dental treatment? Any complaints with treatment received? ☐ yes ☐ no
If yes, please explain: _____

**Do you have any of the following?**

| MOUTH | | | TEETH | | |
|---|---|---|---|---|---|
| Bleeding, sore, swollen gums | ☐ yes | ☐ no | Loose, Broken, Shifting teeth | ☐ yes | ☐ no |
| Unpleasant taste/breath odor | ☐ yes | ☐ no | Sensitive to cold, hot, sweet | ☐ yes | ☐ no |
| Orthodontic treatment | ☐ yes | ☐ no | Clenching/grinding | ☐ yes | ☐ no |
| Clicking/popping jaw or pain | ☐ yes | ☐ no | Tooth pain/discomfort when chewing | ☐ yes | ☐ no |

**On a scale of 1 – 10, with 10 being the highest rating:**

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

**Smile Evaluation**

Do you have any spaces, missing teeth or crowding that you would like to change? ☐ yes ☐ no

Are you interested in changing crowns with metal and/or mercury fillings to metal free? ☐ yes ☐ no

Do you have any teeth or crowns that you are concerned about? ☐ yes ☐ no

Are you happy with the color of your teeth? ☐ yes ☐ no

Are you interested in whitening your teeth or have you done so in the past? When? _____ ☐ yes ☐ no

Are you interested in finding out what your smile could look like with cosmetic imaging? ☐ yes ☐ no

If you could change anything about your smile what would you change? _____

_____

**Sleep Evaluation**

Do you snore or have been told that you snore? ☐ yes ☐ no

Do you often feel tired, fatigued, or sleepy during the daytime? ☐ yes ☐ no

Has anyone observed you stop breathing or gasp for air during your sleep? ☐ yes ☐ no

Do you have or are you being treated for high blood pressure? ☐ yes ☐ no

Have you ever been diagnosed with Sleep Apnea? ☐ yes ☐ no

Are you currently using CPAP or unable to use CPAP? (or any other apnea/snoring device) ☐ yes ☐ no

# ***Insurance Information***

**Initial: _____- We accept assignment of benefits as an OUT OF NETWORK dentist. All benefits are based on estimates from your insurance company and are not exact amounts. By law, your insurance does not release exact amounts to dental practices.**

Name of Insured: _____
Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Birth Date: _____ Social Security #: _____-_____-_____

Group #: _____

Insured's employer name: _____

Dental insurance company name: _____

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

_____ _____
Signature of patient, parent or guardian Date

## Consent for Services

1. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

2. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. **The office staff will estimate insurance coverage to the best of their ability, but the patient agrees that this is an estimate only, not a guarantee of coverage.**

3. *All patient accounts 60 days past due are considered delinquent, and those 90 days past due are subject to collections.

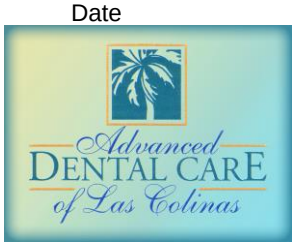
4. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

5. I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to patient

*Jerry Dunn, DDS*




A $50.00 DOLLAR FEE WILL BE CHARGED FOR ALL CANCELLED APPOINTMENTS, WITHOUT 24-HOUR NOTICE

***Advanced Dental Care*** ***Jerry Dunn, DDS***

## *CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION*

**SECTION A: PATIENT GIVING CONSENT**

**Name:** _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person: Kelly Bullock Telephone: 972-506-9688 Fax: 972-506-9321**

**Address: 1075 Kinwest Pkwy, Suite 100, Irving Texas 75063**

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. **You May Refuse to Sign This Acknowledgement**** I have received a copy of this office's Notice of Privacy Practices.

In addition to the above, I give permission to share my health information with the following person/persons.

_____

**Signature:** _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.