Healthy Smiles

Patient Update Information Form

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip code: _____
Telephone Numbers: Home: _____Cell: _____
Email Address: _____

Dental Insurance Information
Policy Holder Name:_____ ID/SSN _____
Employer: _____
Insurance Company _____ Group # : _____

Dental/Medical History:
Do you have any CURRENT dental Problems?_____
Do you have any CURRENT health or medical problems?_____
How long has it been since your last dental appointment?_____
When were your last x-rays taken?_____
What Medications are you currently taking (daily)_____
Have you ever taken BISPHOSPHONATES? (boniva, fosamax, etc) _____
Are you PREGNANT? YES / NO If yes, when is the due date: _____
Do you use tobacco? YES / NO If yes, circle type: Cigars / Cigarettes / Pipe / Chewing Tobacco
How much / How often do you use tobacco: _____

Please Circle Any of the Following That You Have Now or Have Had in the Past:

HIV/AIDS
HPV
Acid Reflux
Anaphylaxis
Arthritis
Artificial Heart Valves
Artificial Joints
Asthma
Anemia
Atopic (allergy prone)
Back Problems
Blood Disease
Cholesterol (High / Low)
Cancer
Chemical Dependency
Cortisone Treatments
Cough (persistent)
Coughing Up Blood
Tonsillitis
Diabetes
Eating Disorder
Epilepsy
Fainting
Food Allergies
Glaucoma
Heart Murmur
Heart Problems: (describe)
_____
Hemophilia (abnormal bleeding)
Herpes
Hepatitis
Hip or Knee Replacement
High Blood Pressure
Jaw Pain
Kidney Disease / Malfunction
Liver Disease
Material Allergies
Tuberculosis
Mitral Valve Prolapse
Nervous Problems
Pacemaker / Heart Surgery
Psychiatric Care
Rapid Weight Loss / Gain
Radiation Treatment
Respiratory Disease
Rheumatic Fever / Scarlet Fever
Shingles / Herpes Zoster
Shortness of Breath
Skin Rash
Spina Bifida
Stroke
Surgical Implant
Swelling of Feet / Ankles
Thyroid Disease
Tobacco Habit
Ulcer / Colitis
Other: _____

Are you ALLERGIC TO or Have You Had a REACTION to Any of the Following: (circle)

Aspirin
Nitrous Oxide
Local Anesthetic
Codeine
Erythromycin
Penicillin
Latex (balloons, gloves, etc)
Sulfa
Other:_____

Signature _____ Date:_____

CONSENT TO PROVIDE DENTAL EXAMINATION

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render diagnosis. This would include an oral examination, radiographs and other diagnostic aids. I have an accurate report of my (or my child's) physical and mental health history. I also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, blood, or any abnormal body, gums, skin, bleeding conditions or any other conditions related to my (or my child's) health or any other physical conditions that my
(or my child's) medical doctor has advised me should be reported to a dentist.

SIGNATURE: ____ DATE: _________________

*****OFFICE POLICIES, MUST READ AND SIGN*****

I am aware that if I **CAN'T** make my appointment, that I need to call at least **48 HOURS** ahead of that scheduled appointment to make other arrangements. Also, I am aware that there shall be a $30.00 no show fee if I miss a scheduled appointment and a $50.00 charge for missing a **CONFIRMED** appointment. These are normal fees for broken appointments, however, if the appointment is longer than one hour, or if it is for a sedation appointment this fee will be larger based on the procedure the appointment was for.

SIGNATURE: ____ DATE: _________________

If a patient is a minor under the age of 18 years old and is in the office for treatment under Nitrous Oxide (laughing gas) an adult must be present with the minor at all times.

SIGNATURE: ____ DATE: _________________

**************PLEASE READ**************:

The majority of insurance companies will not pay for white fillings on posterior teeth, also known as Resin/Composite fillings, nor will they pay for the bases, also known as pulp caps. The bases are placed to protect the nerve of the tooth when the decay has gotten close to the nerve of the tooth. We can submit to the insurance for the covered benefit of an amalgam filling, or silver filling, leaving any additional fee to be an out of pocket expense to the patient. The patient can opt to do amalgam fillings on the posterior teeth as opposed to resin/composite fillings.

Please select which option is preferred on posterior teeth (back teeth):

_________________ Resin/ Composite or White Fillings _______________ Silver/ Amalgam Fillings

**************************************FOR DOCTOR USE ONLY***************************************

Reviewed By: ___________________________ **Medical Alert**:___________________________________

Significant Findings: ____

ASA: I II III IV **TONSILS**: I II III IV

Sedation: Child __________ Teen ____________ Adult _____________ or IV Sedation _________________
Does patient have to take medicines before sedation appointment: Yes No **Medical Release Required**: Yes No
Refer to:____

ASSISTANT RESPONSIBILITY:
Weight: _______________________ Adult Sedation Questionnaire done by: ___________________________

Teen Sedation questionnaire done by: _______________________ Consent signed: ________________________

Note: __________________ Responsible for watching the video: Mom Dad Family Member (specify): _______

FRONT STAFF RESPONSIBILTY:
Pre Authorization: Yes No **Covered by Medicaid**: Yes No **Insurance**: Yes No
Catholic Charity: ________ **Pharmacy Name**: ____________________ **Pharmacy Location: _________________________**