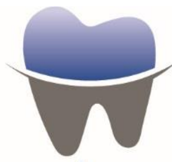

NORTH APPLETON DENTISTRY LLC

3521 COMMERCE CT – APPLETON, WI 54911 – (920)-734-7730

WELCOME TO OUR PRACTICE

Patient Name ______________________________ ___________________________ _______ Preferred Name ________________
(Last Name) (First Name) (MI)

Gender: Male / Female Family Status: Minor / Single / Married / Other Date of Birth ______________________

Social Security #: ______________________________ Driver's License #: ______________________________________

Phone Numbers: ________________________ __________________________ __________________________
(Home) (Work) (Cell)

Address: ____ _________________________ ________ ______________
(Street) (City) (State) (Zip Code)

Email Address: ____

Employer Name: ____ Phone #_______________________________

Whom may we thank for referring you to our practice? ____

In an emergency who should be notified? _______________________________________ Phone #_____________________

Responsible Party Information

This only needs to be filled out if the patient is under the age of 18.

The following information is for the minor patient's Parent or Guardian:

Parent / Guardian Name ________________________________ ________________________________ _________
(Last Name) (First Name) (MI)

Gender: Male / Female Family Status: Minor / Single / Married / Other Date of Birth _________________

Social Security #: _______________________________ Driver's License #:_______________________________

Phone Numbers: _______________________ _________________________ _________________________
(Home) (Work) (Cell)

Address:____ _________________________ ________ _____________
(Street) (City) (State) (Zip Code)

Employer Name: ____ Phone # _____________

Patient Name ______________________________ DOB ______________ Date________________

Primary Dental Insurance

Patient's relationship to insured: (Circle one) Self / Spouse / Child / Other

Name of Insured: ____________________________________ Date of Birth: ___________

Insured's Address: ____

____

Insured's Phone #: __________________

Insured's Employer: ____

SS#: ____________________ Member #: ____________________ Group #: ____________

Insurance Plan Name: ____

Insurance Address: ____

____

Insurance Company Phone #: ______________________

Secondary Dental Insurance

Patient's relationship to insured: (Circle one) Self / Spouse / Child / Other

Name of Insured: ____________________________________ Date of Birth: ___________

Insured's Address: ____

Insured's Phone #: __________________

Insured's Employer: ____

SS#: ____________________ Member #: ____________________ Group #: ____________

Insurance Plan Name: ____

Insurance Address: ____

____

Insurance Company Phone #: ______________________

Patient Name ____________________________________ DOB ________________ Date____________________

Dental Information

Previous Dentist: ____ City/State: _________________________________

How long where you a patient there? _______________ Approximate date of most recent dental exam? ____________

How often do you routinely visit the dentist? ____________________ Have you ever had or been told you should have

periodontal (gum) treatment? _________________________________ If so when? ______________________________

How many times a day do you brush your teeth? ____________________ How often do you floss? _________________

Do you have an immediate dental concern? ____

Are you fearful of dental treatment? ___________ If yes, how fearful on a scale of 1 to 10 (1 being least) ____________

Do you take antibiotic premedication for your dental visits? ______________ If yes, please explain _________________

____

Personal Dental History (Please check all that apply):

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb for treatment
- ☐ Had/have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

Bite and Jaw Joint (Please check all that apply):

- ☐ You have problems with your jaw joint (noise or discomfort)
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
- ☐ Your teeth are becoming crowded or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects or have any other oral habits
- ☐ You clench your teeth in the daytime or clench or grind your teeth at night
- ☐ You have headaches more than once a week
- ☐ You wear or have worn a bite appliance

Tooth structure (Please check all that apply):

- ☐ Cavities within past 3 years
- ☐ Your mouth is dry or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting/craters) on the biting surface of your teeth
- ☐ Any teeth sensitivity to hot, cold, sweets, or avoid brushing part of your mouth
- ☐ Grooves or notches on your teeth, chipped teeth, or have a toothache or cracked filling
- ☐ Food gets caught between your teeth

If any of the checked boxes need further explanation, please describe: ________

____

____

Patient Name ___________________________________ DOB ________________ Date___________________

Medical History

Within the last year, have there been any changes in your general health? ________________

If so what? ____

What is the date or approximate date of your last medical exam? _____________________________

Primary care physician's name: _______________________________ Phone #: _____________________________

Are you allergic to any medications? ____________ If so what? ____

Women only: Are you pregnant or trying to get pregnant? _______________ Due Date: _______________

Have you had major illness or any surgery? ____

Are you on any blood thinners (including daily aspirin)? ____________________________

Have you had problems with bleeding after a cut? _____________

Do you use controlled substances? ____________ If so please list: ____

Please check all that following that apply

☐ Pre-Med Amox	☐ Pre-Med - Clind	☐ Allergy - Erythro	☐ Acid Reflux
☐ Allergy - Sulfa	☐ Allergy - Codeine	☐ Allergy - Other	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Metals	☐ Allergy - Tetracycline	☐ Allergy - Penicillin
☐ Alzheimer's	☐ Allergy - NSAID Drugs	☐ Arthritis	☐ Allergy - Amox
☐ Artificial Joints	☐ Anemia	☐ Blood Disease	☐ Artificial Valve
☐ Cardiac Stents	☐ Asthma	☐ Dizziness	☐ Cancer
☐ Excessive Bleeding	☐ Diabetes	☐ Malignant Hypertherm	☐ Epilepsy
☐ Head Injuries	☐ Fainting	☐ Heart Murmur	☐ Glaucoma
☐ High Blood Pressure	☐ Heart Disease	☐ HIV	☐ Hepatitis
☐ Low Blood Pressure	☐ High Cholesterol	☐ Nervous Disorders	☐ Kidney Disease
☐ Other	☐ Mental Disorders	☐ Pregnancy	☐ Osteoporosis
☐ Radiation/Chemo Tx	☐ Pacemaker	☐ Rheumatic Fever	☐ Psychiatric Tx
☐ Seizures	☐ Respiratory Problems	☐ Stomach Problems	☐ Stroke
☐ Takes Bisphosphonate	☐ Sinus Problems	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Thyroid Disease	☐ Venereal Disease	☐ Use Tobacco Products

If you marked "Other" please explain: ____

Please list all prescription medications, supplements or herbals you regularly take: ________________________________

____

____

Patient Name ________________________________ DOB _______________ Date__________________

Financial Policy

As a condition of treatment by this office, arrangements for payment must be made in advance. Financial responsibility must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or with a credit card at the time services are performed.

It is important that patients with dental insurance understand that all dental services are charge directly to the patient and that he or she is personally responsible for payment of all dental services. We will submit your dental claim to your insurance and credit any collections to your account. Patient copayments are payable at time of service, unless other financial arrangements have been made. If for any reason your insurance company denies your claim you are fully responsible for payment of services provided.

A $5 billing charge will be added monthly to all unpaid balances on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I further acknowledge that fee estimates are based on visual and x-ray assessment and that the actual condition of the tooth may be different and involve a different fee.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand the above information and agree with its contents. _________________________ _____________

(Signature) (Date)

Consent to Treatment

I consent to the diagnostic procedures and treatment by the dentist, hygienist and/or assistant necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) pertinent records to carry out treatment, consult with other practitioners, obtain payment and for those activities and health care operations related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

__________ By Initialing here, I understand the above information and agree with its contents.

Patient Name ______________________________ DOB ______________ Date________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowledgment

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, 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 is available at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice 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.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care:

(Example: Spouse or Parents) ____

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 health care operations.

Print patient Name______________________________ **Date of birth** ____________________

____

(Print Parent or Legal Guardian name if patient is a minor)

____ ______________________________

Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt or acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ Other (Please Specify) ____