Patient Information

STUDIO DENTAL

Please Print

Name_____ Birth date_____

If Child, Parent's Name _____ Sex □ Male □ Female

Home Phone_____ Alternate Phone Number_____

Marital status □ Married □ Single □ Student

Mailing Address_____

City _____ State_____ Zip Code_____

Social Security #_____ Email Address_____

Drivers License#_____ State_____ Exp._____

Emergency Contact Person_____ Phone_____

Do you have dental insurance? □ Yes □No Insurance Company _____

Reason for the visit:_____

Referred by:

□ Newspaper □Flyer □ Friend/Family: Name_____

□Outside Professional □Drive by □Other_____

All Emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. Insurance estimates and "please pay" amounts based on insurance estimates are provided as a courtesy. In the event that your insurance pays less than the estimated amount, **you are responsible for the unpaid balance.**

Patient's Signature _____ Date_____

If Child, Parent's Signature _____

Health Questionnaire

STUDIO DENTAL

Please Print Patient's Name Birth date / /

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you will provide will be kept confidential.

PLEASE ANSWER BY MARKING EACH BOX	**Yes**	**No**
1. Has there been any change in your general health in the past year?.....	☐	☐
2. Have you had any serious illness, operations, or hospitalizations?.....	☐	☐
If so , describe and give approximate dates:_____		
3. Have you ever had intravenous sedation or general anesthesia?	☐	☐
Were there any adverse effects? …….....	☐	☐

4. **DO YOU HAVE OR HAVE YOU EVER HAD**: (Place an **X** in each box that applies to you)

☐ AIDS/HIV	☐ Emphysema	☐ Nervous Disorders	☐ Ulcers
☐ Anemia	☐ Epilepsy/Seizure	☐ Neurologic Disorders	☐ Venereal Disease
☐ Angioplasty	☐ Excessive Bleeding	☐ Pacemaker	☐ Codeine Allergy
☐ Arthritis	☐ Fainting	☐ Pneumonia	☐ Penicillin Allergy
☐ Artificial Joints/Implants	☐ Glaucoma	☐ Radiation Treatment	☐ Amoxicillin Allergy
☐ Asthma	☐ Hay Fever	☐ Respiratory Problems	☐ Latex Allergy
☐ Blood Disease	☐ Heart Disease	☐ Rheumatic Fever	☐ Local Anesthetic Allergy
☐ Blood Transfusions	☐ Heart Murmur	☐ Rheumatism	☐ Aspirin/Ibuprofen Allergy
☐ Bronchitis	☐ Hepatitis	☐ Sinus Problems	☐ Cephalosporin Allergy
☐ Cancer	☐ High Blood Pressure	☐ Stomach Problems	☐ Barbiturates Allergy
☐ Chronic Cough	☐ Jaundice	☐ Stroke	☐ Sedatives Allergy
☐ Coronary Artery Disease	☐ Kidney Disease	☐ Thyroid Disease(Hypo/Hyper)	
☐ Diabetes	☐ Liver Disease	☐ Tuberculosis	
☐ Dizziness	☐ Mental Disorders	☐ Tumors	

5. **PLEASE LIST ALL CURRENT MEDICATIONS (Including over the counter)** _____

_____

6. **Other allergies or reactions please List:** _____

_____

7. Do you smoke? How many per day_____ For how long_____ Yes ☐ No ☐

8**. WOMEN**	**Yes**	**No**
A. Are you taking birth control pills? ……	☐	☐
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant?	☐	☐
If Yes when is your due date?_____		
C. Are you BREAST FEEDING? …….	☐	☐
D. Are you taking hormonal replacement? ……...	☐	☐

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ **X** _____

Date Signature

CONSENT TO DISCLOSE
PRIVATE HEALTHCARE INFORMATION

FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

I, _____(Patient), Social Security Number_____, date of birth _____, hereby authorize and consent for STUDIO DENTAL associates, to release any and all medical, dental, and/or psychological reports or records, including, but not limited to, Dentist's orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patient progress reports, diagnosis, post-operative, reports, post operative diagnosis, pathology reports, X-rays, MRI's, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any X-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical / dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations. The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other health care operations. A copy of this authorization is agreed by the undersigned to have the same effect and force as an original Any person, firm, or entity that releases matters pursuant to this authorization is herby absolved from any liability that might otherwise result from the release of those matters.

General Consent For Treatment

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

- Cleaning of teeth and application of topical fluoride.
- Application of sealants to the grooves of teeth.
- Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
- Stainless steel crowns for children. These 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 (crown, partials, 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 malposed (crooked) teeth and /or developmental abnormalities.
- The use of sedative medications and /or nitrous oxide to control apprehensions and/ or disruptive behavior.

The treatment has been explained to me. 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 have been explained: however, the possibility and nature of complications cannot be accurately anticipate. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his /her judgment will in the best interest of me or my child's health, once treatment has been initiated.

Although their occurrence is rate and unpredictable, some risks are known to be associated with dental or oral surgery 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, hospitalization and in very rare cases death.

I hereby state 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 that I choose to terminate. Such termination of consent must be in writing.

Patient Name:_____

Signature of patient/ Guardian:_____ Date: _____