DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Sanford Dental Excellence
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Date:_____ Cell (_____)_____ Alternate (_____)_____

PATIENT INFORMATION

Name _____ SS # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Patient Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____) _____

DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec #. _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address _____

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Primary Care Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs used to treat Osteoporosis? These include, but are not limited to, Fosamax, Boniva, Atetria, Actonel, Reclast, Evista, Micalcin, Forteo, and Prolia. ☐ Yes ☐ No Please list _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Do you regularly take Aspirin/Blood Thinner? ☐ Yes ☐ No Do you have any allergies to metal or jewelry? ☐ Yes ☐ No

Are you currently under the care of a doctor for pain management? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ COPD
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Defibrillator
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
  - ☐ Vape
  - ☐ Marijuana
  - ☐ Cannabis
  - ☐ Smokeless tobacco
  - ☐ Cigarettes
- ☐ Tuberculosis
- ☐ Ulcer

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Signature of Doctor _____ Medical Clearance needed for treatment: ☐ YES ☐ NO

Consent to the Use and Disclosure of Dental health Information For Treatment, Payment, or Dental Healthcare Operations

I understand that as part of my dental healthcare, this organization originated and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine dental healthcare operations such as assessing quality and reviewing the competence of dental healthcare professionals.

I have been informed of and have been given the right to review a *NOTICE OF INFORMATION PRACTICES* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation I will be provided a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my dental health information for directory purposes. I understand that I have the right to request restrictions as to how my dental health information may be used or disclosed to carry out treatment, payment, or dental healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my dental health information:

_____

I authorize the following individual(s) to discuss my dental healthcare with office personnel:

_____

Signature of Patient or Legal Representative ***Witness***

Signature:_____ Signature: _____

Date: _____ Date: _____

Doctor

Signature:_____ Date: _____

Informed Consent for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, and referrals to other dentists or specialists, and return for scheduled appointments. IF you fail to follow the advice of your dentist, you may increase the chance of a poor outcome.

Certain heart conditions may create a risk or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he can consult with your physician if necessary. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications associated with dental treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment.
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. A root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
11. Allergic reaction to anesthetic or medication.
12. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have ready, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Print Patient name	Date	Witness	Date
Patient Signature	Date	Parent/Legal Guardian	Date
Doctor Signature	Date		