# Fountain View Dentistry

## Patient Information

Thank you for visiting our office! To assist us in serving you, please complete the following confidential form. The information provided is essential to your dental health.

Patient Name _____Preferred Name _____
Birth Date _____ Social Security # _____ If minor, parents names _____
Address _____ City _____ State_____ ZIP _____
Home Phone_____ Cell _____ Work_____
Employer _____
Email Address _____

Emergency Contact: Name _____
Relationship _____ Phone_____
How did you hear about our office? _____

## Insurance Information

Name of Primary Ins Co _____
Subscriber Name _____ Relationship to Pt _____ Date of Birth _____
Group # _____ Subscriber # _____
Subscriber employed by _____ Subscriber Social Security # _____
Insurance Co Address _____
Insurance Co Phone _____ Insurance Co Website_____

Name of Secondary Ins Co _____
Subscriber Name _____ Relationship to Pt _____ Date of Birth _____
Group # _____ Subscriber # _____
Subscriber employed by _____ Subscriber Social Security # _____
Insurance Co Address _____
Insurance Co Phone _____ Insurance Co Website_____

◇ I do not currently have any dental insurance.

# Medical and Dental History

Patient Name: _____ D.O.B._____

**Medical History**

1. Physician_____ Address/Phone_____
2. When was your last physical examination?_____
3. Are you under the care of a physician . . . . . ☐ Yes ☐ No
4. Are you presently taking any medications/drugs/pills/herbals/supplements. . . . . ☐ Yes ☐ No
   If yes, please list: _____
   _____
5. (Women) Is there a chance you are pregnant?☐ Yes ☐ No If yes, anticipated due date? _____
6. Do you take oral contraceptives? . . . . . ☐ Yes ☐ No
7. Are you allergic/sensitive to: ☐ None☐ Codeine ☐ Penicillin☐ Local Anesthetic☐ Latex☐ Erythromycin ☐ Sulfur ☐ Other _____
8. Do you smoke, chew tobacco, or use E-cigarettes . . . . . ☐ Yes ☐ No
   If yes, please indicate which one(s), daily frequency, and how long? _____
9. Do you have, or have you ever had:

| | | | | | |
|---|---|---|---|---|---|
| Abnormal blood pressure. . . . . | ☐ Yes | ☐ No | Heart Pacemaker. . . . . | ☐ Yes | ☐ No |
| AFIB/Irregular Heartbeat. . . . . | ☐ Yes | ☐ No | Heart Surgery . . . . . | ☐ Yes | ☐ No |
| Alzheimer Disease . . . . . | ☐ Yes | ☐ No | Heart Disease ☐Yes ☐ No Heart Murmur | ☐ Yes | ☐ No |
| Anemia. . . . . | ☐ Yes | ☐ No | Hepatitis (Type ___.) . . . . . | ☐ Yes | ☐ No |
| Arthritis. . . . . | ☐ Yes | ☐ No | HIV positive/ AIDS. . . . . | ☐ Yes | ☐ No |
| Artificial heart valve/stent/graft. | ☐ Yes | ☐ No | Jaundice. . . . . | ☐ Yes | ☐ No |
| Artificial joint replacements. . … | ☐ Yes | ☐ No | Kidney Troubles/Dialysis. . . . . | ☐ Yes | ☐ No |
| Asthma. . . . . | ☐ Yes | ☐ No | Leukemia. . . . . | ☐ Yes | ☐ No |
| Blood Disease. . . . . | ☐ Yes | ☐ No | Liver Disease. . . . . | ☐ Yes | ☐ No |
| Cancer. . . . . | ☐ Yes | ☐ No | Mitral Valve Prolapse. . . . . | ☐ Yes | ☐ No |
| Chemical dependency. . . . . | ☐ Yes | ☐ No | Oral herpetic lesions (Cold Sores) . . … | ☐ Yes | ☐ No |
| Chemotherapy/radiation. . . . . | ☐ Yes | ☐ No | Osteoporosis/ Bisphosphonates Tx. . .. | ☐ Yes | ☐ No |
| Cold Sores/Fever blisters. . . . . | ☐ Yes | ☐ No | Rheumatic fever. . . . . | ☐ Yes | ☐ No |
| Congenital heart defects. . . . . | ☐ Yes | ☐ No | Sinus trouble . . . . . | ☐ Yes | ☐ No |
| Corticosteroid treatment. . . . . | ☐ Yes | ☐ No | Stroke . . . . . | ☐ Yes | ☐ No |
| Epilepsy/seizures. . . . . | ☐ Yes | ☐ No | Thyroid problem. . . . . | ☐ Yes | ☐ No |
| Excessive or prolonged bleeding. | ☐ Yes | ☐ No | Tuberculosis or Lung Disease. . . . . | ☐ Yes | ☐ No |
| Fainting spells. . . . . | ☐ Yes | ☐ No | Ulcers/GERD . . . . . | ☐ Yes | ☐ No |
| Glaucoma. . . . . | ☐ Yes | ☐ No | Diabetes (Type_____). . . . . | ☐ Yes | ☐ No |

10. Do you take pre-medication for anything? . . . . . ☐ Yes ☐ No If yes, what for? _____
11. Have you had any other serious illness, hospitalization, or accident? . . . . . ☐ Yes ☐ No
    If yes, please explain: _____

# Medical and Dental History

**Dental History**

1. Former Dentist_____ Phone Number_____
2. When did you last visit a dentist?_____ When was your last cleaning?_____
   X-rays taken? . . . . ☐ Yes ☐ No . . . . . If yes ☐ Full Mouth ☐ Bitewings ☐ Panoramic
   What was done at your last visit? _____
   Why did you leave that dental office? _____
   Has any dental treatment been recommended to you that you have not had done? _____
   _____
3. Do you wear dentures ☐ Yes ☐ No. . . Partials ☐ Yes ☐ No
4. Do you have any dental implants . . . . . ☐ Yes ☐ No
5. Are you aware of any dental problems . . . . . ☐ Yes ☐ No
   If yes, please explain: _____
6. Please rate the present condition of your mouth: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***
7. Have you ever been treated for gum disease/gum treatment/scaling &root planning . . . . . ☐ Yes ☐ No
   If yes, what was done? _____
8. Do your gums bleed when brushing or flossing . . . . . ☐ Yes ☐ No
9. Do you have any lumps or sores in your mouth. . . . . ☐ Yes ☐ No
10. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure
11. Please rate the appearance of your smile: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***
    a. Would you like a whiter smile? . . . . . ☐ Yes ☐ No
    b. Would you like straighter teeth? . . . . . ☐ Yes ☐ No
    c. Have you had your teeth straightened/worn braces? . . . . . ☐ Yes ☐ No
12. Are you concerned with snoring or sleep apnea? . . . . . ☐ Yes ☐ No
13. Are you grinding or clenching your teeth (bruxism)? ☐ Yes ☐ No Do you wear a bite guard. . . . . ☐ Yes ☐ No
14. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?) ☐ Yes ☐ No
15. Do you have headaches. . . . . ☐ Yes ☐ No
16. Is there anything else that would be valuable for your dentist to know to best care for you? _____
    _____

☐ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

☐ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist/specialist.

Patient Signature_____ Date: _____
(Parent/ Guardian)

Dentist Signature _____ Date: _____

# HIPAA

Effective April 14, 2003, the federal law known as Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Wisconsin Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to obtain written consent prior to disclosing any of your information except for disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or healthcare professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## Patient Acknowledgement and Consent

Please sign this form below to acknowledge that you have today reviewed our Notice of Privacy Practices and that you consent to our disclosures of your information that we deem necessary in order to provide you with the proper treatment.

Signature _____ Date _____
Print Name _____

## Authorization to Release Information

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Please print name Relationship

_____ _____
Please print name Relationship

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

- The individual refused to sign.
- An emergency situation prevented us from obtaining the acknowledgement.
- Communication barriers prohibited obtaining the acknowledgement.
- Other (please explain

# Financial Agreement

## Appointments

We value your time, so we will make every attempt to see you at your appointed time and keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time as this time is reserved for you. If you must change an appointment, please provide at least 48 hours, if possible, advanced notification so we may accommodate other patients.

## Financial Policy

At our office, we care about you and your dental health, so we offer choices for paying for your dental care. We accept the following forms of payment: cash, check, Visa, MasterCard, American Express, Discover and some third-party financing (like CareCredit).

## Insurance Policy

All insurance co-pays and deductibles must be paid at the time of service. We will submit all pertinent information electronically to your insurance company and help you to maximize your dental benefits while receiving your personalized dental care. In the event that we do not get payment from the insurance company, the balance will be required to be paid by you.

## Acknowledgements (please initial)

_____ I authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
_____ I authorize the dentist to release all information necessary to secure the payment of benefits.
_____ I understand I am financially responsible for all charges whether or not insurance pays.
_____ I have read and acknowledge the Financial Policy.
_____ Payment is due in full at time of service unless prior arrangements have been approved.

Signature _____ Date _____

Patient/Responsible Party Signature _____

Relationship to Patient _____