Patient Health Information

TOWNCENTER DENTISTRY AND ORTHODONTICS

Name:_____ Date: _____

Physician's Name:_____ Date Last Seen:_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No
Please list each one: _____

Are you taking any medications? ❑ Yes ❑ No
Please list each one: _____

Do you use tobacco in any form?: ❑ Yes ❑No

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
❑	❑	Abnormal Bleeding	❑	❑	HIV+ Aids	❑	❑	Stroke
❑	❑	Alcohol Abuse	❑	❑	Heart Attack: When?___	❑	❑	Thyroid Problems
❑	❑	Allergies	❑	❑	Heart Murmur	❑	❑	Tuberculosis
❑	❑	Angina Pectoris	❑	❑	Heart Surgery			
❑	❑	Arthritis	❑	❑	Hepatitis B			
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis C			
❑	❑	Asthma	❑	❑	High Blood Pressure			
❑	❑	Cancer	❑	❑	Joint Replacement			
❑	❑	Chemotherapy	❑	❑	Kidney Problems			
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease			
❑	❑	Diabetes	❑	❑	Low Blood Pressure			
❑	❑	Drug Abuse	❑	❑	Pacemaker			
❑	❑	Emphysema	❑	❑	Psychiatric Problems			
❑	❑	Epilepsy	❑	❑	Rheumatic Fever			
❑	❑	Fainting Spells	❑	❑	Seizures			
❑	❑	Frequent Headaches	❑	❑	Sexually Transmitted Disease			
❑	❑	Glaucoma	❑	❑	Sinus Problems			

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Latex
❑	❑	Penicillin
❑	❑	Tetracyline

Yes	No	If Female,
❑	❑	Are you taking Birth Control pills?
❑	❑	Are you pregnant? If so, # of weeks ___
❑	❑	Are you nursing?

Is there any other disease/condition not listed above? _____

Please check if you have had or have any of the following:

- ❑ Bad breath
- ❑ Bad tastes
- ❑ Bite nails/objects
- ❑ Bleeding gums
- ❑ Chew on one side
- ❑ Clenching/grinding teeth
- ❑ Clicking/popping of jaw
- ❑ Difficulty chewing
- ❑ Dry mouth
- ❑ Gag easily
- ❑ Infection in gums
- ❑ Jaw pain/soreness
- ❑ Loose teeth
- ❑ Mouth sores
- ❑ Missing teeth
- ❑ Sensitive gums
- ❑ Sensitive to: ❑Hot ❑Cold ❑Sweets
- ❑ Stained teeth

I understand that the information that I have given today is the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____

Medical History Update

Date: _____ ❑ Changes: _____ ❑ None Signature: _____

Date: _____ ❑ Changes: _____ ❑ None Signature: _____

Date: _____ ❑ Changes: _____ ❑ None Signature: _____

Town Center Dentistry and Orthodontics

Patient Information Sheet

Whom may we thank for referring you to our dental and orthodontic practice? _____

Patient Name _____ ☐ Married ☐ Single ☐ Minor
Last First MI

Address _____ Date of Birth ___/___/___
Street Apt. # City State Zip Month Day Year

Telephone Home: ( ) _____-_____ Work: ( ) _____-_____ E-Mail _____

Place of Employment _____ Dental Insurance Co. _____

Group # _____ If Full Time Student, Name of School _____

Has any member of your family been treated in our practice? ☐ Yes ☐ No

Insured Information

Primary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

Secondary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

Acknowledgement and Authority

- The Information on this page and the dental/medical histories are correct to the best of my knowledge.
- I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payers and/or other health professionals, as appropriate under the circumstances.
- I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangement have been made in writing with a practice representative.
- I have received a copy of the HIPAA Privacy Policy as required by law.
- I grant the dental office permission to use the email address given above to contact me with respect to my dental care.

X _____
☐ Adult Pt. ☐ Father/ Mother ☐ Guardian

Person to Contact in Case of Emergency

Name _____

Address _____

Telephone # (____)_____-_____

TOWN CENTER DENTISTRY AND ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For office use only

_____

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

- Individual refused to sign __
- Communications barriers prohibited obtaining the acknowledgement __
- An emergency situation prevented us from obtaining acknowledgement __
- Other (please specify)_____

_____

This form is educational only, does not constitute legal advice and covers only federal , not state, law (August 14, 2002).
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_____

Financial Agreement

All patients, please read the following:

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. I authorize my signature below to be used as a signature on file for any credit card payment used over the phone or that I placed on file to be used to pay for treatment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, collection agency cost, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee of $500 will be added.

I understand that it is required to give 2 working days (Mon.-Fri.) notice if an appointment needs to be cancelled, or rescheduled. If I fail to give proper notice I agree to pay a $50 missed appointment fee that will be added to my account.

If the need should arise, due to the work and materials involved, there is a $25 fee for the transfer of records.

I have read and understood the above financial policy.

_____ _____

Print Name Date

Information informed consent

ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. Injury to the nerves: This would include injuries causing numbness of the lips; the tongue; any tissue of the mouth; and/or cheeks or face. This numbness which could occur may be of a temporary nature, lasting a few days, a few weeks a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
2. Bleeding, bruising, swelling: Bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if sever, you should notify us. Bruises or hematomas may persist for some time.
3. Dry socket: This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful.
4. Sinus involvement: In some cases, the root tips of upper teeth lie in close apposition to the tissues of the sinuses. Occasionally during extraction or surgical procedures, this sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.
5. Infection: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment infections may occur postoperatively. At times these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received.
6. Fractured jaw, roots, bone fragments, or instruments: Although extreme care will be used, the jaw, teeth roots, bone spicules, or instruments used in the extraction procedures may fracture or be fractured, requiring referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery which could cause more harm and add to the risk of complications.
7. Injury to adjacent teeth or fillings: This could occur at times no matter how carefully surgical and/or extraction procedures are performed.
8. Bacterial endocarditis: Because of the normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and bacterial endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems known or suspected.
9. Unusual reactions to medications given or prescribed: Reactions, either mild or severe, may possible occur from anesthetics or other medications administered or prescribed. All prescription d\rugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period. It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given to me.

Informed consent: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care from an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print)	Signature of patient	Date
Tooth No. (s) _____		
_____	Witness to signature	Date

Retention

Now that your orthodontic appliances have been removed, you are ready to graduate into your final, but very important phase of treatment. This is called retention. To retain means "to hold". Because teeth move and shift all of our lives, a retainer will prevent them from doing so. The hours you will be required to wear your retainers will vary from patient to patient and our office will supervise your retention for the first 24 months after your appliances have been removed.

Your retainers are custom made for your teeth and they are fragile, so please be careful. No appliance is ever broken or lost when worn correctly. **THE SAFEST PLACE FOR YOUR RETAINERS IS IN YOUR MOUTH!!** Don't wrap it in a napkin, put it in your pocket or leave it out for curious children or hungry dogs! Please notify our office immediately if your retainer is lost or broken, we need to replace it as soon as possible before the teeth begin to shift. There will be an additional charge for each lost or broken retainer. Retainers may be removable and/or fixed.

Orthodontists through the years have found that about 95% of correction is retained, but natural forces such as chewing may cause shifting eventually. This readjustment is not a failure of your correction, but is nature. It is advised that you continue wearing your retainers indefinitely while sleeping.

We recommend that you continue to see your family dentist for a through check-up and cleaning. They will be anxious to see how well you have responded to treatment.
It has been a pleasure having you for a patient. **You have beautiful teeth, SO SMILE!**

We appreciate your confidence in your practice and would welcome the opportunity to treat your friends and family.

BRING YOUR RETAINER TO EACH OF YOUR APPOINTMENTS!

RETENTION INFORMED CONSENT

I have been given complete instructions regarding the wear and care of the retainers and have had all of my questions answered. I understand that failure to wear the retainers may result in **tooth movement toward their original positions-a condition termed "relapse".**

Retreatment may be required if I fail to follow instructions properly, and I agree not to hold Dr. Gina Kessler, D.D.S.,M.S. responsible for any problem that should arise as a result of my lack of responsibility. I agree to cover all costs incurred if treatment is required due to my lack of responsibility.

_____

Signature of Parent Date

_____

Signature of Patient Date