Dawson Dental Group

Patient Information

Patient Name:____ Name you would like to be called: ____________________________________

Date of Birth:__________________ Social Security Number:____________________________ Email:____

Home Phone:_____________________________ Work Phone:____________________________ Cell Phone:___________________________________

Address:____ City:________________________ State:_________ Zip Code:________________

Employer Name:____ Employer Address:____

Some services we provide MAY be billable to medical insurance, please fill out BOTH insurance sections accurately.

Medical Insurance Information

Policy Holder Name:_____________________________Date of Birth:________________

Social Security Number:___________________ Employer:_________________________

Patient Relationship to Policy Holder:____

Insurance Company:____

Insurance Phone Number:____

Policy ID Number:____________________________Group Number:__________________

Dental Insurance Information:

Policy Holder Name:_____________________________Date of Birth:________________

Social Security Number:___________________ Employer:_________________________

Patient Relationship to Policy Holder:____

Insurance Company:____

Insurance Phone Number:____

Policy ID Number:____________________________Group Number:__________________

Dental History

Reason for todays visit?____ **Date of last exam/cleaning**___________________________________

Name of previous dentist:_____________________________________ Reason for transferring dentists:____

How did you hear about us?____

What is the most important thing about your initial dental visit:____

Continue ⇨

Medical History

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive.

Allergies
Acrylics Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulfa Y N
List other known allergies:

____

____

____

Cardiovascular
Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine
Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat
Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus Y N

Gastrointestinal
Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

Genitourinary
Frequent Urination Y N
Kidney disease Y N
Nocturia Y N

General
Current weight: _________lbs
Height: _______ ft ______in
Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N

Hematological
Bleeding problems Y N
Hepatitis Y N

Oral
Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficulty chewing? Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth clenching Y N
Teeth grinding Y N
Tooth pain Y N
Wisdom teeth extraction Y N
Do you wear dentures or partials? Y N
Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal
Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N

Neurological
Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric
ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating disorders Y N
Excessive Stress Y N
Memory problems Y N

Respiratory
Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea (shortness of breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep
Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often? ___________________
Has anyone told you that you snore? Y N

Social History
Do you smoke? N Y ___ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages?
_____Drinks per day/week/month

Do you use recreational drugs? Y N

□ **Yes** □ **No** **Have you ever taken bisphosphonates such as Boniva, Actonel, Fosamax, Zometa or Reclast?**

□ **Yes** □ **No** **Have you ever been told that you have a blood clotting disorder such as Hemophilia or Von Wildebrand's disease?**

□ **Yes** □ **No** **Are you currently taking anticoagulants (blood thinners) such as Coumadin, Aspirin, Plavix, Xarelto, or Eliquis?**

FEMALES: Are you pregnant or nursing? □ Yes □ No If yes, what is your due date?____

List any medications you are taking:

Medication	**Dosage/Freq.**	**Prescriber**	**Reason**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

List any surgeries or hospitalizations you have had:

(Including Artificial Joints)

Date (year)	**Surgery**	**Surgeon**

List and detail any medical condition or history not listed above:

____

____

____

____

Primary Physician's Name: ____ Physician's phone #: ______________________

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

General Consent for Dental Treatment

I understand the purpose of this consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate to provide me with more specific informed consent discussion. I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks. My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care. I understand that some after-treatment effects and complications tend to occur with regularity. I understand that I need to disclose all medications I am taking including any herbal supplements as they may cause an adverse reaction with medications that I am giving while in the office or prescribed. For the administration of local anesthetic, I understand that for many treatments and procedures I will be given an injection and that in a certain number of cases patients have had an adverse reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of post-operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment. I understand that all treatments and procedures have a risk of separation of dental instruments which may become lodged in a gum or other soft tissue or aspirated. I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery. I have the right to ask Dr. Nagar for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use this right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedures, and my alternative to the procedure.

Guidelines for Radiographs & Dental Records:

Radiographs in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination radiographs are generally taken every six months. However, the frequency at which radiographs are taken will be based upon individual dental need.

Cancellation or Missed Appointment Guidelines:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. In order to continue providing exceptional care in a timely manner, we have set-forth guidelines which we follow for any failed or late notice cancellation appointments. We require 48 hours notice to cancel or change an appointment. We respect your time and make every effort to keep you from waiting but need your help to continue. After the first violation, we will send a letter to you reminding you of the guidelines we have set in place. Should you fail or give late notice of a cancellation a second time your account will be charged $50.00. After the third violation, in addition to another $50.00 charge, we will require pre-payment for all future appointments which is non-refundable should you miss or give late notice canceling.

Financial & Insurance Guidelines:

It is our goal to provide you with leading edge dental technologies, the finest dental materials, and expert team in a comfortable environment. **In order to provide this quality of dental care, we require all of our patients to pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your insurance claims with the insurance company for the treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.** I authorize Dawson Dental Group and Dr. Nagar to bill my insurance companies on behalf of myself and to use my signature on all insurance claims. Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, and not our dental office. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. However, we cannot let your insurance company dictate your oral care. Our goal is to help you achieve and maintain optimal dental care. We charge what is usual and customary for our area. For your convenience, we accept Cash, Check, Visa/Master Card, American Express, Discover and Care Credit.

Any accounts past due over 90 days may be sent to a collection agency. Collection fees will apply. In the event my account is turned over to an outside collection agency, I understand that I am responsible for all costs incurred by Dawson Dental Group, LLC.

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

I have read the above guidelines and agree to their content. I understand the guidelines are subject to change anytime without notice.
I have answered truthfully and to the best of my knowledge the medical questionare section of the packet.

Patient Name ______________________ Patient/Guardian Signature ______________________ Date ______________________

***Please REMOVE all jewelry from the neck up including earrings, tongue rings, other piercings, as well as necklaces in preparation for radiographs.**