Dawson Dental Group

Patient Information

Today's Date:_____ All questions contained in this questionnaire are strictly confidential and will become part of your medical record

PATIENT INFORMATION		
Name:		Preferred Name:
Date of Birth:	Social Security Number:	☐ Male ☐ Female
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	
Email Address:		

EMPLOYMENT INFORMATION	
Employer Name:	Job Title:
Employer Address:	Employer Phone Number:

EMERGENCY CONTACT INFORMATION	
Emergency Contact Name:	Relationship to Patient:
Phone 1:	Phone 2:

DENTAL INSURANCE INFORMATION	
Policy Holder Name:	Relationship to Patient:
Date of Birth:	Social Security Number:
Insurance Company:	Employer:
Insurance Phone Number:	
Member ID:	Group Number:

Medical Insurance Information	
Policy Holder Name:	Relationship to Patient:
Date of Birth:	Social Security Number:
Insurance Company:	Employer:
Insurance Phone Number:	
Member ID:	Group Number

REFERRAL INFORMATION
When visiting a dentist what is the most important thing to you?
How did you hear about us?

DENTAL HISTORY
Reason for Today's Visit:
Name of Previous Dentist:
Date of Last Cleaning:

MEDICAL HISTORY

ALL lines must be checked either YES or NO

A patient's medical history is a vital part of his or her dental history. A complete medical history increases the dentist's awareness of diseases and medication which might interfere with your dental treatment. Please answer if you currently or have had in the past the following:

PATIENT INFO
Name: _____
Date: _____
Current Weight: _____ lbs.
Height: _____ ft. _____ in.

ALLERGIES	YES	NO
Aspirin	☐	☐
Codeine	☐	☐
Dental Anesthetics	☐	☐
Erythromycin	☐	☐
Latex	☐	☐
Metals	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐
Sulfa	☐	☐
Seasonal Allergies	☐	☐
Dairy / Tree Nuts / Other Food	☐	☐
List any other known allergies below:		
_____		
_____		

CARDIOVASCULAR	YES	NO
Artificial Heart Valve	☐	☐
Coronary Artery Disease	☐	☐
Chest Pain or Angina	☐	☐
Congestive Heart Failure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
High Cholesterol	☐	☐
Irregular Heart Beat	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Tachycardia	☐	☐
Bradycardic	☐	☐

ENDOCRINE	YES	NO
Diabetes	☐	☐
Gout	☐	☐
Hormonal Change	☐	☐
Thyroid Problems	☐	☐

HEMATOLOGICAL	YES	NO
Bleeding Problems	☐	☐
Hepatitis	☐	☐
HIV / AIDS	☐	☐
HPV Human Papilloma Virus	☐	☐

GASTROINTESTINAL	YES	NO
Acid Reflux	☐	☐
GERD	☐	☐
Soft or Special Diet	☐	☐
Ulcers	☐	☐
Liver Problems	☐	☐

ORAL HEALTH	YES	NO
Bleeding Gums	☐	☐
Fever Blisters / Mouth Sores	☐	☐
Dry Mouth	☐	☐
Jaw Joint Problems (TMJ)	☐	☐
*Pain (jaw, face or ear)	☐	☐
*Difficulty Chewing	☐	☐
*Clicking or Locking of the Jaw Joint	☐	☐
Orthodontics/Invisalign	☐	☐
Periodontal Disease	☐	☐
Gum Disease	☐	☐
Teeth Clenching	☐	☐
Teeth Grinding	☐	☐
Tooth Pain	☐	☐
Wisdom Teeth Extraction	☐	☐
Night Guard Usage	☐	☐
Removable Oral Appliance	☐	☐

ONCOLOGY	YES	NO
Cancer, Oral	☐	☐
Cancer, Head & Neck	☐	☐
Radiation Treatment	☐	☐
Chemotherapy	☐	☐
List any other types of cancer or cancer treatments you have received below:		
_____		
_____		
_____		
_____		

GENERAL	YES	NO
Headaches	☐	☐
Rheumatic Fever	☐	☐
Weight Change	☐	☐
Trauma or Injury (Recent)	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Kidney Disease	☐	☐

MUSCULOSKELETAL	YES	NO
Back Pain Chronic	☐	☐
Fibromyalgia	☐	☐
Joint Pain	☐	☐
Joint Replacement	☐	☐
*What Joint: _____		
*When Replaced: _____		
Multiple Sclerosis (MS)	☐	☐
Muscle Weakness	☐	☐
Tingling / Numbness	☐	☐

NEUROLOGICAL	YES	NO
Alzheimer's Disease	☐	☐
Memory Loss	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Trigeminal Neuralgia	☐	☐
Tremor	☐	☐

MENTAL HEALTH	YES	NO
ADD / ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Eating Disorders	☐	☐
Stress Coping Issues	☐	☐
Mental Disorder(s)	☐	☐
Sensory Processing Issues	☐	☐
Nail Biting	☐	☐
Sensory Processing Disorder	☐	☐

ENT (Ear, Nose & Throat)	YES	NO
Change in Hearing	☐	☐
Change in Vision	☐	☐
Difficulty Swallowing	☐	☐
Ear Pain	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Nasal Obstruction	☐	☐
Nose Bleeding	☐	☐
Sinus Problems	☐	☐
Tonsillectomy	☐	☐
Tinnitus	☐	☐

RESPIRATORY	YES	NO
Asthma	☐	☐
Bronchitis Chronic	☐	☐
Emphysema / COPD	☐	☐
Breathing Problems General	☐	☐
Chest Pressure	☐	☐
Congestion	☐	☐
Dyspnea (Shortness of Breath)	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐

SLEEP	YES	NO
Daytime Sleepiness	☐	☐
Morning Headaches	☐	☐
Obstructive Sleep Apnea	☐	☐
CPAP/BiPAP?	☐	☐
Snore	☐	☐

SOCIAL HISTORY	YES	NO
Smoke – Cigarettes / Vape	☐	☐
Smokeless Tobacco	☐	☐
Alcohol Abuse	☐	☐
Recreational Drug Use	☐	☐
Prescription Drug Abuse	☐	☐

OFFICE USE ONLY
_____
_____
_____
_____

WOMEN'S HEALTH	YES	NO
Are you pregnant?	☐	☐
If yes, how many weeks?_____ Due Date:_____		
Are you nursing?	☐	☐
Are you taking any birth control? (If YES please list below)	☐	☐

ORAL APPLIANCE SAFETY	YES	NO
Do you wear dentures?	☐	☐
How old are your dentures?_____		
Do you wear a partial?	☐	☐
How old is your partial?_____		
Do you wear a night guard?	☐	☐
How old is your night guard?_____		

HEALTH HISTORY QUESTIONNAIRE		
YES ☐	NO ☐	Do you or have you ever used teeth whitening or bleaching products?
YES ☐	NO ☐	Have you ever received treatment for or diagnosed with Osteoporosis and or a similar disease?
YES ☐	NO ☐	Have you ever taken bisphosphonates such as Boniva, Actonel, Fosamax, Zometa, Prolia or Reclast? (If YES please list below)
YES ☐	NO ☐	Have you ever been told that you have a blood clotting disorder? Hemophilia, Von Wildebrand's Disease?
YES ☐	NO ☐	Are you currently taking anticoagulants (blood thinners) such as Coumadin, Aspirin, Plavis, Xarelto, or Eliquis? (If YES please list below)
YES ☐	NO ☐	Have you ever been diagnosed with Human Papilloma Virus (HPV)?
YES ☐	NO ☐	When was the last time you had a comprehensive Oral Cancer Screening?
YES ☐	NO ☐	Are you taking any over the counter, holistic, herbal medications and or any supplements? (If YES please list below)
YES ☐	NO ☐	Are you taking any Prescription Medications? (If YES please list below)

Please list any prescribed, over the counter and or herbal medications you are taking below.

Medication	Dosage / Frequency	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list any SURGERIS or HOSPITALIZATIONS you have had

Date (Year)	Surgery
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

PHYSICIAN CONTACT INFORMATION				
Are you under the care of a Primary Care Physician?	YES ☐	NO ☐	Physician's Name:	Phone#:
Are you under the care of any other Physician?	YES ☐	NO ☐	Physician's Name:	Phone#:

PLEASE LIST ANY MEDICAL CONDITIONS OR HISTORY NOT LISTED ABOVE:

Office Policies

Please read, sign and date each section

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 give a reminder 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.

Signature _____ Date _____

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. **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.** Should you have more than one insurance company, all patient portions and collections will be calculated based only on primary**,** after primary pays, we will submit claims to secondary insurance, should you end with a credit, you have the choice to have that remain on the account or a refund issued. I authorize Dawson Dental Group 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. 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.

Payment is due at the time of service. Payment arrangements should be discussed prior to receiving services. For your convenience, we accept Cash, Visa/Master Card, American Express, Discover and Care Credit.

Signature _____ Date _____

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.

Signature _____ Date _____

Authorization to Release Health Records to External Parties

Please list any individuals we have permission to discuss your dental treatment/records with.

Name _____ Relationship _____

Name _____ Relationship _____

PLEASE REMOVE ALL JEWELRY FROM THE NECK UP INCLUDING EARRINGS, TONGUE RINGS, OTHER PIERCINGS, AS WELL AS NECKLACES IN PREPARATION FOR RADIOGRAPHS (XRAYS).