PATIENT INFORMATION FORM

bluetree FAMILY DENTAL

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Email: _____

Name of Spouse or Responsible Party: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Email: _____

Primary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Secondary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Tertiary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Primary Care Provider Name: _____ Phone: _____

Preferred Pharmacy with Location: _____

Referred By (Please Circle): Social Media Friends/Family Google Mailer Billboard Doctor

Drive/Walk By Word of Mouth Doctor:_____Other:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Medical History

Patient Name_____**Age**_____

Please Indicate if you have or have had any of the following. (Place an X to indicate)

- ☐ Taking Blood Thinners
- ☐ Bleeding Disorder
- ☐ High Blood Pressure
- ☐ Heart Attack - Year_____
- ☐ Heart Infection
- ☐ Heart Problems/Defect – Type _____
- ☐ Born With A Heart Defect – Repaired? Yes No
- ☐ Heart Valve Replacement
- ☐ Heart Surgery - Type_____
- ☐ Aneurysm
- ☐ Cardiac Pacemaker
- ☐ Stroke - Year_____
- ☐ Cancer – (Active or History?) Type_____
- ☐ Cancer Meds/Chemo – When? _____
- ☐ Radiation Therapy - Location_____
- ☐ HIV/AIDS
- ☐ Hepatitis - Type_____
- ☐ Other Infectious Disease _____
- ☐ Pregnant - Trimester_____
- ☐ Trying To Get Pregnant
- ☐ Breast Feeding
- ☐ Birth Control Hormones
- ☐ Diabetes - Controlled Well / Fair / Poor
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Glaucoma Type: _____
- ☐ Osteoporosis Medication / Name:_____
- ☐ IV Drug Medications - Type_____
- ☐ Joint Replacement - Date of Surgery _____
- ☐ Tuberculosis – Cleared by Physician? Yes No
- ☐ History of Drug Dependency
- ☐ Tobacco or Vape Use – Type _____
- ☐ Acid Reflux (GERD)
- ☐ Asthma – (Mild / Mod / Severe)
- ☐ Sinus Problems
- ☐ Dental Anxiety (Mild / Mod / Severe)
- ☐ Mental Health Issues
- ☐ Sensory Processing Issues
- ☐ Fibromyalgia
- ☐ Epilepsy or Convulsions
- ☐ History of Long Term Steroid Treatments
- ☐ Anaphylaxis or Severe Allergic Reaction
- ☐ Autoimmune Disease _____
- ☐ Immune System Issues _____
- ☐ Breathing Problems or Emphysema
- ☐ Other Condition Not Listed _____

(YES / NO) Are you **allergic** to any medications or materials? Please check or list **ALL** allergies

- ☐ Amoxicillin/Penicillin
- ☐ Codeine
- ☐ Lidocaine/Anesthetic
- ☐ Epinephrine
- ☐ Latex
- ☐ Advil/Ibuprofen
- ☐ Tylenol/Acetaminophen
- ☐ Narcotics/Norco/Vicodin
- ☐ Valium/Xanax/Halcion

Other:_____

(YES / NO) Are you taking any **medications**? – please list **ALL** meds _____

_____

I have filled out this form accurately and to the best of my knowledge. I have had all my questions answered, and I understanded that an accurate healthy history is vital to my wellbeing.

Signature:_____Date_____

Dental History

Patient Name_____**Age**_____

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

- ☐ Dental Anxiety (Mild) (Mod) (Severe)
- ☐ Impairment in (Speech) (Hearing) (Vision)
- ☐ Tooth Pain or Discomfort
- ☐ Orthodontic Treatment (Braces/Invisalign)
- ☐ Sores or Lumps Around or in Your Mouth
- ☐ Any Broken or Defective Teeth/Restorations
- ☐ Periodontal Therapy
- ☐ Bleeding Gums

Please indicate if you have or have had any of the following Joint or facial pain symptoms:

- ☐ Jaw Joint Pain
- ☐ Jaw Joint Clicking or Popping
- ☐ Jaw locking or Unable to Open or Close
- ☐ Headaches or Facial Pain
- ☐ Whiplash or Trauma to the Head
- ☐ Frequent Headaches

Please indicate if you have or have had any of the following sleep apnea symptoms.:

- ☐ Daytime Tiredness or Desire to Nap
- ☐ Snoring or Other Noises During Sleep
- ☐ Sleep Walking or Talking
- ☐ Bed Wetting
- ☐ ADHD in Children
- ☐ Frequent Awakening

How Important is your dental health to you? (with 10 being the highest)

1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? (with 10 being the highest)

1 2 3 4 5 6 7 8 9 10

Please indicate if you have an immediate desire for more information on the following:

- ☐ Whitening of Teeth
- ☐ Cosmetic Dentistry
- ☐ Replacing Metal Fillings
- ☐ Replacing Missing Teeth
- ☐ Orthodontic/Invisalign
- ☐ Dental Implants

When was your last dental cleaning?

_____month(s) ago or _____year(s) ago

When was your last dental treatment?

_____month(s) ago or _____year(s) ago

Please tell us about any other dental history that would help us get to know you:

_____

_____

_____

_____

Payment/Insurance Policy

- **Payment Policy:** Payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for all balances imposed by their insurance. You are ultimately responsible for any remaining amount unpaid by insurance. There will be a $50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and will incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Patients are responsible for determining whether or not our providers are considered part of their insurer's network and will be responsible for all balances imposed by their insurance company. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.
- **Patient Signatures Release of Information to Insurers and Assignment of Benefits:** To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively to evaluate and administer claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.
- **Confirmation of Appointments:** Appointments will be attempted to be confirmed before your scheduled appointment. You must confirm your appointment or your appointment will be canceled.
- **Missed or Broken Appointments:** If you miss or break your appointment with less than 24 hours' notice, you will be subject to a $50-$100 cancellation fee.
- **Social Media/Photo Consent:** I consent to use images taken of me/my child to showcase our extraordinary care. I understand that the office may post my images on any/all social media platforms and websites.
- **Consent to Treat:** I give the dentists and dental hygienists permission to treat me in the dental office with exams, cleanings, x-rays, fillings, crowns and other dental procedures deemed advisable by our clinicians. While the vast majority of dental procedures cause little to no unwanted side effects, I understand there are risks to dental treatment, including but not limited to the following:
    - Post-anesthetic injection complications can be psychologically and physically disabling, including bruising, limited opening, pain, dysfunction, as well as nerve damage. Needles can very rarely be separated inside the tissue and require surgery to remove.
    - Aspiration of dental materials leading to emergency surgery.
    - Damage to the jaw joint can occur in susceptible individuals, leading to pain and dysfunction of the jaw joint, which can be psychologically and physically disabling.
    - Post-Surgical infections, swelling, pain, fever, and nerve damage, can occur. I understand that I must immediately notify my dentist if any of these conditions occur. I will seek emergency medical care if the infection appears to be more than minor.
    - Dental treatment is highly effective and predictable; however, in some cases, treatment fails due to various reasons including, but not limited to, pre-existing conditions such as cracks in the teeth, severe decay and bone loss, patients not following up with timely appointments to complete treatment, health issues such as diabetes and complications of smoking, complex root canal systems leading to residual infections, diets high in sugar or soda, and your general health.
    - Allergic reactions can happen in the dental office. In exceedingly rare instances, these reactions can be life-threatening.
    - Post-cleaning sensitivity can occur. This is especially true if you have periodontal disease. If this happens, please contact the office, as we have topical medications to help.
- **Communication from Bluetree Brands:** I consent to receive relevant communication from Bluetree brands and its affiliated partners.

We will do our absolute best to ensure you get the best care at our office. Please feel free to ask any questions regarding your treatment.

I have carefully read and given my consent to all the above sections on this form. I have had any questions regarding this form sufficiently answered to my satisfaction.

Patient Name: _____ Date: _____

Guardian Name if Applicable: _____

Signature of Patient/Guardian: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

_____

Please Print Patient Name

_____

Signature of Patient/Legal Guardian

_____

Date

The notice contains a patient's rights section describing your rights under the law. You certify by your signature that you have reviewed our notices before signing this consent. The terms of the notices are subject to change.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement if we do. The HIPAA (Health Insurance Portability and Accountability Act of 1996 Law) allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By submitting this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as the law allows.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition treatment receipt upon this consent's execution.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You may communicate with the following individuals relating to the patient's medical or payment information:

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of our Notice of Privacy Practices was attempted, however acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

_____