Welcome to True Dental Group

Patient Name_____

How do you prefer to be addressed?_____

Mailing Address_____

City_____ State_____ Zip _____

Birth Date _____/_____/_____ Age_____ Sex: M F

Marital Status: Single Married Widow Separated Divorced

Cell Phone (_____)_____-_____ Home Phone (____)_____-_____

Occupation_____ Employer_____

Time with current employer _____ Work Phone (_____)_____-_____

Business Address_____ City _____State _____Zip____

Driver License Number_____ Social Security Number _____-_____-_____

Email Address_____

Responsible Party Information (if different from patient)

Name_____ Relationship to patient_____

Mailing Address_____

City_____ State_____ Zip _____

Birth Date _____/_____/_____ Age_____ Sex: M F

Cell Phone (_____)_____-_____ Home Phone (____)_____-_____

Occupation_____ Employer_____

Time with current employer _____ Work Phone (_____)_____-_____

Business Address_____ City_____State_____Zip____

Do you give permission to any other person to give consent for treatment: Yes or No
Who can consent for treatment_____

Person to Contact in Case of Emergency

Name_____ Phone: (_____)_____-_____

Staying Connected

True Dental Group has installed integrated telephone technology, merging our office software with our phone system. We now have the ability to both receive and send out text messages to our patients. What is the best cell phone number for you?

Cell phone:(_____)_____-_____

Please circle yes or no below

Yes: I authorize True Dental Group to communicate with me by text message.
No: Please do not send me text messages

What is the best email address for you?_____

Please circle yes or no below

Yes: I authorize True Dental Group to communicate with me by email.
No: Please do not send me emails

You can reach us online at: Thetruedentalgroup.com and Truesleepkc.com

You can also email us at: Truedentalgroup@gmail.com

Acknowledgement of Receipt of Notice of Privacy Policy

you may refuse to sign this acknowledgement

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

_____ _____ _____
Legal Name (Printed) Signature Date

Office Use Only: Reason for Refusal to Sign_____

Authorization to Release Information

I hereby authorize this facility to release my protected health information to:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____ _____
Name Phone Number

Insurance Information

Dental Insurance: Primary Policy

Insurance name_____

Address_____

Policy Holder Name_____ Relationship to Patient_____

Policy Holder Social Security Number_____-____-_____ Member ID_____

Group Number_____ Policy Holder Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Dental Insurance: Secondary Policy

Insurance name_____

Address_____

Policy Holder Name_____ Relationship to Patient_____

Policy Holder Social Security Number_____-____-_____ Member ID_____

Group Number_____ Policy Holder Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Medical Insurance: Sometimes we can submit claims for dental procedures to your medical insurance to help maximize all of your benefits.

Insurance name_____

Address_____

Policy Holder Name_____ Relationship to Patient_____

Policy Holder Social Security Number_____-____-_____ Member ID_____

Group Number_____ Policy Holder Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Dental History

What brings you to our office today?_____

When was the last time you were seen by a dentist?_____

Are you suffering from any oral pain or discomfort?	Yes	No
Do you like the way your smile looks?	Yes	No
Have you ever wanted to have whiter teeth?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Have you ever been told that you have gum disease?	Yes	No
Do you still have your wisdom teeth?	Yes	No
Are you missing any teeth?	Yes	No
Do you grind or clench your teeth at night or during the day?	Yes	No
Do you feel nervous about receiving dental treatment?	Yes	No
Have you ever had Nitrous Oxide (Laughing Gas) for dental treatment?	Yes	No

Consent

As the undersigned, I hereby authorize the Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent the Doctor to choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due payable at the time services are rendered.

All proceeds of insurance are assigned to the doctor when applicable, but without the doctor assuming responsibility for the collection of those claims. If the insurance does not pay my claim within 60 days after it is mailed, it is understood that I will pay the balance of my account and that I will contract my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage.

If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge will be added to my account. The billing charge will be a periodic rate of 1.5% per month (or a minimum charge of $5.00 for a balance under $100) which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to attorney fees and court costs. I understand that, where appropriate, credit reports may be obtained.

Signature of Patient (Guardian)_____ Date _____/_____/_____

Medical History

Name of your Primary Medical Doctor _____

Phone Number of your Primary Medical Doctor (_____)_____-_____

Name of your Specialty Doctor (i.e. cardiologist) _____

Phone Number of Specialty Doctor (_____) _____-_____

Last time you were seen by a medical Doctor _____

Have you had any ER visits or hospitalizations within the last year? Yes No

If yes, please describe_____

Do you smoke? Yes No

Do you use smokeless tobacco? Yes No

Women: Are you Pregnant, or think you might be? Yes No

If Yes, when is your due date? _____/_____/_____

Medications/Drug Allergies

Please circle any medication listed below that you are allergic to, or have had a bad reaction to:

Aspirin	Iodine	Vicodin	Hydrocodone	Oxycodone
Codeine	Tylenol	Ibuprofen	Tramadol	Penicillin
Amoxicillin	Erythromoycin	Keflex	Z-Pack	Lidocaine
Tetracycline	Clydamycin	Sulfa	Nirtrous Oxide	

Please list all medications you take on a regular basis: _____

_____

Please list any medication you have taken in the last six months that you do not take on a regular basis:

_____

Please circle the medical conditions that apply to you:

High Blood Pressure	Aids	Hemophilia
Diabetes	Alcoholism	Hepatitis
Heart Attack	Anemia	HIV
Stroke	Angina	Hives
Joint replacement	Asthma	Hyper Activity
Osteoporosis	Birth Control	Hypoglycemia
Congenital Heart Defect	Low blood pressure	Jaundice
Blood Thinners	Bruise Easy	Kidney Disease
Epilepsy/ Seizures	Deaf	Liver Disease
Drug Dependency	Drug Dependency	Mitral Valve Prolapse
Chronic Pain Therapy	Eating Disorder	Night Sweats
Cancer	Emphysema	Paralysis
Chemotherapy	Fainting Dizzy Spells	Psychiatric Treatment
Radiation Therapy	Cold Sores	Rheumatic fever
Obstructive Sleep Apnea	Gag Easy	Sickle Cell Disease
Cpap Machine	Glaucoma	Sinus Problems
Gerd/Acid Reflux	Headaches- frequent	STDs
ADHD	Hives	Tuberculosis

Please list any other serious illness or medical condition not listed above:

_____

Jaw and Airway Assessment

Clicking of the jaw joints	Yes	No
Pain in or around the ears	Yes	No
Difficulty opening or closing the mouth	Yes	No
Difficulty chewing	Yes	No
History of trauma to the jaw	Yes	No
Do you snore loudly	Yes	No
Do you grind/clench your teeth	Yes	No
Do you feel tired or fatigued during the day	Yes	No
Have you ever been diagnosed with TMJ/TMD	Yes	No
Have you ever had your Airway Measured	Yes	No

How did you hear about our office?

_____

Was our office easy to find?

_____

Did you have any trouble finding a parking spot?

_____