# 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 (____)________-_____________

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 (____)________-_____________

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

## 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 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________________________________________________

Policy Holder Name____________________ Relationship to Patient_________

Policy Holder Social Security Number_____-____-_____ Member ID___________

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

Name of Employer____________

## Dental Insurance: Secondary Policy

Insurance name________________________________________________

Policy Holder Name____________________ Relationship to Patient_________

Policy Holder Social Security Number_____-____-_____ Member ID___________

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

Name of Employer____________

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

Insurance name________________________________________________

Policy Holder Name____________________ Relationship to Patient_________

Policy Holder Social Security Number_____-____-_____ Member ID___________

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

Name of Employer____________

## 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 ____________________________________

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 | Latex |

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?

______________________________________________