

# DENTAL HISTORY

**Please check any of the following problems that apply to you.**

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

**Do you have or have you had any of the following?**

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

**Name of Previous Dentist** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

**Do you smoke or use chewing tobacco?**   
How much? \_\_\_\_\_ For how long? \_\_\_\_\_

**If I could change my smile, I would:**

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal fillings with natural, tooth-colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**On a scale of 1 – 10, with 10 being the highest rating:**

- How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?** \_\_\_\_\_

**What is the most important thing to you about your future smile and dental health?** \_\_\_\_\_

**What is the most important thing to you about your dental visit today?** \_\_\_\_\_

# MEDICAL HISTORY

**Please check any of the following that apply to you:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions           | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Respiratory Problems   |  |

**Do you have any of the following drug allergies?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Percodan         | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other        |

**Is there any other medical or dental information we should know about?** \_\_\_\_\_

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_

**Are you under a physician's care? What for?** \_\_\_\_\_

**Are you taking any medications? What?** \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**TO OUR PATIENTS:**

We would like to take this opportunity to welcome you to our practice. We feel that we can provide the best service for you if you are aware of our office policies concerning office hours, fee structures, dental insurance, payment arrangements, scheduling and failure to keep appointments.

**OFFICE HOURS:**

Monday 8:30-5:00. Tuesday 8:30-5:00, Thursday 8:30-5:00 and Friday 8:30-5:00

**DENTAL INSURANCE:**

Dental insurance is a wonderful benefit. We want to help each patient maximize insurance benefits! We will help by supplying claim forms with correct coding and any supporting documentation that is appropriate, including narrative reports, copies of x-rays and photos in an envelope with postage affixed, for you to simply drop in the mail. We make dental care financially comfortable. Our goal is not to let expense keep you from the quality care you deserve and desire.

**FINANCIAL POLICY:**

Payment is expected at the time services are rendered. We accept cash, checks, and all major credit cards (MasterCard, Visa, American Express and Discover). Third party financing is available through Care Credit and Capital One often at no or low interest rates for qualified applicants. We also offer a prepayment courtesy (savings) for advanced payment of proposed treatment.

**SCHEDULING:**

All appointments are scheduled in such a manner as to allow Dr. Mitchell to devote his entire attention and concentration to each individual patient. **We ask that each patient schedule their appointment at a time that is not only convenient but also possible to keep. Any time a patient fails an appointment, that time is lost forever.**

**FAILURE TO KEEP APPOINTMENTS:**

We realize that there can be unexpected circumstances to cause a failed appointment. However, we reserve the right to charge each patient for failed appointments. A broken appointment hurts three people... you, the patient who could have taken your appointment, and the staff that was waiting to serve you.

If we do not receive 48 hours (2 business days) notice of cancellation for an appointment, the charge will be as follows:

1. A \$55.00 (fifty-five dollar) charge for hygiene appointment.
2. A minimum \$100.00 (one-hundred dollar) charge for an appointment with Dr. Mitchell.

\_\_\_\_\_  
Signed (Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Robert Mitchell, DDS, PA

# Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Consent to release information to: \_\_\_\_\_

Date: \_\_\_\_\_