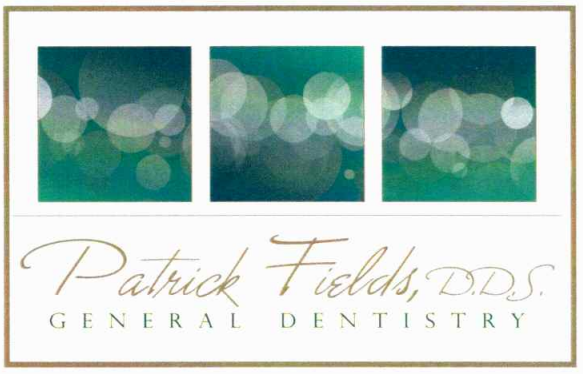
WELCOME TO OUR PRACTICE



Patrick Fields, D.D.S.
GENERAL DENTISTRY

WE BRING SMILES TO LIFE

1 ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI Mr. Ms. Mrs. Dr.

SS # (Patient): _____/_____/_____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Minor

I prefer to be called: _____

Birthdate: _____/_____/_____ Age: _____

Home Address: _____

_____
CITY STATE ZIP

Hm #: (____)_____ Pager/Cell #: (____)_____

Wk #: (____)_____ Ext:_____

Employer:_____

Occupation: _____

Hobbies and Interests: _____

Other family members seen by us: _____

Person Responsible for Account: _____

Relation: _____ DOB:_____

Billing Address: _____

Hm #: (____)_____ Wk #: (____)_____

Whom may we thank for referring you?

_____

The world always looks brighter from behind a smile.

2 CONTACT

Because we know your life is busy, we use an Electronic Appointment Reminder and Messaging System.

Please ✓ all that you prefer, as our best way to contact you.

❑ Email
(Email address_____)

❑ Text Message

❑ Personal Phone Call
- ❑ Home
- ❑ Work
- ❑ Cell

❑ Don't need a reminder

We shall never know all the good that a simple smile can do.

3 INSURANCE BENEFIT

PRIMARY Dental Coverage: ❑ Yes ❑ No

Insured's Name: _____

Insured's Birthdate:_____/_____/_____ Insured ID / SS#: _____

Insured's Employer: _____

Insurance Co. Name: _____

Group #: _____

SECONDARY Dental Coverage: ❑ Yes ❑ No

Insured's Name: _____

Insured's Birthdate:_____/_____/_____ Insured ID / SS#: _____

Insured's Employer: _____

Insurance Co. Name: _____

Group #: _____

All the statistics in the world can't measure the warmth of a smile.

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ___	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

GENERAL DENTISTRY

New Patient Policy

Adults (18 and over)

At your first appointment we will do our absolute best to make sure that we fully examine your oral health. To do this accurately, we must have two (2) kinds of x-rays. The first kind is what we call a Full Mouth Series. It consists of eighteen (18) x-rays that show each tooth. These are vital to properly diagnose cavities. The second kind is called a panoramic x-ray. This shows the jawbone, TMJ joint, and wisdom teeth, and can be used to determine areas of significant bone loss and malnormities (lesions, cyst, etc.) that cannot be seen on traditional x-rays. **The price of the panoramic x-ray normally runs $100, but since insurance will not cover It and the full mouth series taken at the same time, we have reduced the price to $15 as a service to our patients.** If you have had either of these x-rays within the past three (3) years, please let us know in advance. We ask that you obtain them from your previous dentist and bring them in with you or have them sent to us. Again, both of these x-rays are very important for us to maintain your oral health.

If you have any questions about the above treatment, please feel free to ask. Otherwise, we do ask that you pay the $15 at your appointment in addition to any other co-pays or deductibles due.

Financial Agreement

Insurance Consent Form

I authorize release of any information concerning my (or my child's) dental health and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign benefits to **Patrick Fields, DDS**, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance forms. I understand that the office will file my insurance for me and that my insurance benefits can only be estimated based on information the insurance company provides. **I understand that I am financially responsible for all charges whether or not paid by Insurance.**

Our office does not carry long term accounts. For your convenience, our office offers the following methods of payment: cash, check, Visa, MasterCard, Discover, and Carecredit. Any account balance that has not received payment within 45 days will be considered for collection by an outside agency. I agree to pay the collection agency fee of 40% of my unpaid balance, in addition to the balance due, should the provider deem necessary to employ a collection agency to assist in the recovery of my account.

_____ _____

Signature of responsible party Date

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you frequently get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

Patrick and Ashley Fields Family Dentistry, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Patrick and Ashley Fields Family Dentistry PA's Notice of Privacy Practices ("Notice) and that:

The Notice informs me on how Patrick and Ashley Fields Family Dentistry, PA will use my Health information for the purposes of my treatment, payment for my treatment, and Patrick and Ashley Fields Family Dentistry PA's health care operations;

The Notice provides details on how Patrick and Ashley Fields Family Dentistry, PA may use or share my health information for purposes other than treatment, payment, and the conducting of health care operations; and

Patrick and Ashley Fields Family Dentistry, PA will use or share my protected health information as required or permitted by law.

Patient Name (please print) Date

Patient signature (if over 18 years old) OR Signature of Personal Representative

Authority of personal representative to sign for patient (check one):

__ parent
__guardian
__power of attorney
__ other:_____

Please Note: It is your right to refuse to sign this acknowledgement

Office use only:

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the individual noted above, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement
___ A communication barrier prevented us from obtaining acknowledgement
___ The individual was unwilling to sign
___ Other: _____

Staff member signature_____ Date_____