PATRICK FIELDS, D.D.S
GENERAL DENTISTRY

Patient Personal Information

Patient Name: _____

Nickname: _____ Male Female

DOB: _____/_____/_____ SSN: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Status: Child Single Married Widowed Divorced

Employer or school name: _____

How did you hear about us? _____

Spouse's name: _____

Do you have children? Yes No How many? _____

Responsible Party

Name: _____

Nickname: _____ Male Female

Relation to patient: _____

DOB: _____/_____/_____ SSN: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In Event of Emergency

Emergency contact: _____

Relation to patient: _____

Emergency contact phone: _____

Insurance Information

Primary **Yes** **No**

Group ID: _____ Phone #: _____-_____-_____

Insurance Company: _____

Employer Name: _____

Subscriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Subscriber ID: _____ DOB: _____/_____/_____

Secondary **Yes** **No**

Group ID: _____ Phone #: _____-_____-_____

Insurance Company: _____

Employer Name: _____

Subscriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Subscriber ID: _____ DOB: ___/___/_____

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Medical History

Are you currently under the care of a physician? Y N
If yes, what is the condition being treated? _____
_____
Physician Name: _____
Physician's Phone #: _____
Please list all prescription and over the counter medications you are currently taking: _____
_____
_____
_____

Do you have a pain management contract? Y N
If yes, who is the physician? _____

Have you had any serious illness, operation, or been hospitalized in the last five years? Y N
If yes, explain: _____
_____

Do you require an antibiotic before dental work? Y N
Do you use tobacco in any form? Y N
If yes, what type and how often? _____
Do you consume alcohol? Y N
If yes, how often? _____

Women Only:

Y N Birth Control Y N Pregnant
Y N Nursing If so, how many weeks? _____

Allergies

Y N Aspirin
Y N Codeine
Y N Dental Anesthetic
Y N Erythromycin
Y N Iodine
Y N Latex
Y N Metals
Y N Penicillin
Y N Plastics
Y N Red Dye
Y N Sulfa Drugs
Y N Tetracycline
Y N Other: _____
_____
_____

Medical History

Y N ADD/ADHD
Y N AIDS or HIV Infection
Y N Anaphylaxis
Y N Anemia
Y N Arthritis
Y N Artificial Joints
Y N Artificial Valves
Y N Asthma
Y N Autism/Sensory Disorder
Y N Behavior Problems
Y N Cancer
Y N Cleft Lip/Palate
Y N Congenital Heart Defect
Y N Diabetes - Type 1
Y N Diabetes - Type 2
Y N Drug/Alcohol Abuse
Y N Eating Disorder
Y N Emphysema
Y N Epilepsy
Y N Fainting
Y N Fever Blisters
Y N Frequent Cough
Y N Frequent Headaches
Y N Hearing Impairment
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N Hypoglycemia
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Pain in Jaw Joints
Y N Psychiatric Care
Y N Radiation
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Trouble
Y N Stomach Trouble
Y N Stroke
Y N Thyroid Problem
Y N Tuberculosis
Y N Ulcers
Y N Other: _____
_____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient or Guardian: _____ Date: _____

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GENERAL DENTISTRY

Dental History

What prompted you to come to the dentist today? Routine care, no problems Tooth pain Gum problems

Need teeth repaired or fixed Other: _____

How long has it been since your last dental exam and cleaning? _____

Who was your previous dentist? _____ City: _____ State: _____

How many times per day do you brush your teeth? _____ How many days per week do you floss your teeth? _____

Please answer the following:	**Check One:**	**If yes, please explain:**
Have you had any discomfort from your teeth or gums lately?	Y N	_____
Are your teeth sensitive to hot, cold, or sweets?	Y N	_____
Do you have sensitivity when you chew or bite down?	Y N	_____
Are you concerned with bad breath?	Y N	_____
Do you like your smile?	Y N	_____
Do your teeth need to be whiter?	Y N	_____
Do your gums bleed when you brush or floss?	Y N	_____
Have you ever had periodontal disease?	Y N	_____
Have you ever had orthodontic treatment (braces)?	Y N	_____
Have your teeth shifted in position or alignment in the last year?	Y N	_____
Does food often get stuck between certain teeth?	Y N	_____
Do you have more than one headache per week?	Y N	_____
Do you have pain radiating in your jaw (into your neck and shoulders)?	Y N	_____
Do you have difficulty opening your mouth less than 3 fingers width?	Y N	_____
Do you have muscle spasms that cause difficulty swallowing?	Y N	_____
Does your jaw pop or click when you open or close your mouth?	Y N	_____
Do you habitually grind or clench your teeth?	Y N	_____
Have you been diagnosed with sleep apnea?	Y N	_____
Are you using a CPAP machine?	Y N	_____
Do you now wear or expect to wear dentures someday?	Y N	_____
Do you have missing teeth you want to get replaced?	Y N	_____
Do you habitually chew on anything?	Y N	_____
Do you frequently snack on sweets?	Y N	_____
Does going to the dentist cause you anxiety?	Y N	_____
Have you ever had a particularly bad experience at the dentist?	Y N	_____

Is there anything else about your dental history you would like us to know?

_____

_____

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_____ Initial

Payment and Dental Insurance Policy

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made prior to treatment. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filling a claim with my insurance company does not relieve me from my responsibility for the payment of all charges incurred. As a courtesy to our patients, we will file most dental insurances with your insurance company. For some insurance policies, we are able to estimate the benefits from your insurance plan. Our estimates are not a guarantee of payment and any balance resulting from a lower reimbursement from your insurance than initially estimated is due in full. In addition, if the insurance company fails to make payment within 60 days, the entire balance becomes due from the patient.

_____ Initial

Photo and Video Release

I hereby grant Rock Family Dental the right and unrestricted permission to use photos/videos taken of me (or my child), or in which I (or my child) may be included with others, and to use, reuse, publish, and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising, and trade, or any other purpose whatsoever without restriction.

_____ Initial

Appointment Policy

In order to offer the best dental services to our patients, our office reserves individual appointment times for every patient. Should something occur that requires you to break your scheduled appointment, we ask that you give a minimum of 48 hours notice for any appointment changes or cancellations, yet earlier notification is greatly appreciated. We ask that you arrive on time for your scheduled appointments. We reserve the right to charge for broken appointments when less than 48 hours notice is given. After 2 consecutive missed appointments, it is our policy to not reschedule you for any further appointments.

_____ Initial

Text and Email Policy

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. You assume the risks of using email and text message. Message and data rates may apply through your carrier.

_____ Initial

Consent to Receive Treatment

Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ Initial

Notice of Privacy Policy

We care about your privacy and the privacy of your personal health information. By law, we are required to maintain your privacy, and to give you notice of our privacy policies and practices, if requested. Our Privacy Policy is displayed in our offices, can be viewed on our website, and a printed copy is available upon request.

Please list below any person who can receive PHI (Protected Health Information) on this patient.

Name	**Relationship**	**Treatment Info**		**Ledger**	
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No

Patient or Guardian: _____ **Date:** _____