DUTCHTOWN
DENTAL CENTER

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth (mm/dd/yyyy): _____ Social Security # ___-___-___ Drivers Lic: _____

Email Address: _____

Would you like to receive confirmations via: ☐ Email ☐ Text

What days & times are you available on short notice for appointments? _____

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

EMERGENCY CONTACT: (Person not living with you to notify in case of emergency)

Name: _____ Cell Phone: _____

Relationship to patient: _____

Please check all of the ways that you have heard about us

☐ Radio
☐ Phone Book
☐ Drive by / Sign
☐ Postcard / Mailer
☐ Website
☐ Referred by Patient/ Friend: _____
☐ Online Search Engine (i.e. Google): _____
☐ Other: _____

MEDICAID INSURANCE SCHEDULING AGREEMENT

At Dutchtown Dental Center, we accept Medicaid insurance, however, **WE ARE NOT A MEDICAID OFFICE**. When we make your appointment, we assume that the appointment is a confirmed appointment, but as a courtesy to you, we contact you the day before your appointment, as a reminder. As a result of this process, your appointment cannot be changed once it is made. However, we understand that circumstances arise that cause us to change our schedules. SO, if you have to change your appointment, we will need a 24-48 hour notice to do so. As long as we have this notice, we will reschedule you again for treatment in this office. **IF WE DO NOT RECEIVE AT LEAST 24 HOURS NOTICE TO CHANGE AN APPOINTMENT, WE WILL NOT BE ABLE TO RESERVE TIME ON OUR SCHEDULE FOR FURTHER TREATMENT AT THIS OFFICE.** You will be put on a short term list in which we will call you if we have openings in the schedule that day. Therefore, **it is important that you are ON TIME for and also KEEP your appointment.** Thank you for your cooperation and understanding and may God bless you and yours!

Patient's name (please print): _____

Patient's signature: _____ Date: _____
(Parent / Guardian's signature if patient is a minor)

DUTCHTOWN DENTAL CENTER

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ☐ Yes ☐ No If yes, explain: _____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, explain: _____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, explain: _____
- Are you taking any medication, pills, or drugs? ☐ Yes ☐ No If yes, explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
- Have you ever taken Fosamax, Boniva, Acetonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

- **Have you ever had any serious illness not listed above?** ☐ Yes ☐ No _____
- **Are you nervous about dental visits?** ☐ Yes ☐ No
- **Do you need antibiotic pre-medication before dental visits?(for reasons such as Mitral Valve Prolapse or artificial joints)** ☐ Yes ☐ No
- **Do you snore, wake up with headaches, or have trouble remembering things?** ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DUTCHTOWN
DENTAL CENTER

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('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 acknowledge that I have received your Notice of Privacy Practices which contains a complete description of the use and disclosures of my health information. 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 Private Practices.*

Patient's name (please print): _____

Patient's signature: _____ Date: _____
(Parent/Guardian's signature if patient is a minor)

Relationship to patient (if patient is minor): _____

Anyone you want allowed access to your file: _____

MEDICAID INSURANCE INFORMATION

In some cases, Medicaid insurance **DOES NOT COVER ALL DENTAL PROCEDURES AND TREATMENT**. Waiting periods and restrictions apply in certain cases. For instance, if the patient has been referred from another dentist and has had a cleaning and/or X-rays in the past 6 months, Medicaid will not cover that treatment. We cannot use X-rays from another dental office, therefore, **the cost becomes the patient's responsibility**. Also, sedation dental visits are only covered twice a year. Orthodontic and TMJ cases are not covered by Medicaid insurance. These are just a few general restrictions with Medicaid insurance, and we will inform the patient of any and all special limits or conditions with their insurance concerning their individual dental treatment at this office. THE COST OF TREATMENT THAT IS NEEDED OR REQUIRED AT DUTCHTOWN DENTAL CENTER AND **IS NOT COVERED** BY MEDICAID INSURANCE WILL BE THE **PATIENT'S RESPONSIBILITY!**
Thank you.

The above policy has been explained to me and I fully understand the conditions of this policy.

_____ _____
Patient Signature (Parent/Guardian if minor) Date

DUTCHTOWN
DENTAL CENTER

COSENT FOR DENTAL TREATMENT AND
ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

Infection	Injuries to adjacent teeth and/or hard, soft tissue
Bleeding	Dry Socket
Failure of wound to heal	Incomplete removal of tooth
Loss of teeth	Injury to adjacent structures
Loss of bone	Allergic reaction to drugs
Instrument breakage	Tooth or fragment in maxillary sinus
Bacterial endocarditis	Death (in rare cases)
Breakage of root(s) and retained root fragments	Parasthesia or numbness of tongue and/or mouth, and/or face
Swallowing and/or aspiration of objects	Fracture of mandible (lower jaw) or maxilla (upper jaw)
Failure of treatment to accomplish main purpose	Slough (unanticipated loss of hard and/or soft tissue)
Trismus (jaw pain or difficulty opening mouth)	Opening between mouth and sinus or mouth and nose

Additional oral surgery, hospitalization, and/or further treatment may be required in the event of any complication(s).

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical, orthodontic or dental treatment agreed upon between doctor and patient or parent / guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. This consent form will remain valid unless revoked by me in writing.

_____ _____

Patient Signature (Parent/Guardian if minor) Date