Oak Ridge DENTAL ARTS

Patient Information and Health Update

In order to keep your record accurate, please complete all sections, sign, and date below.

You may be required to update this form yearly.

Date: _____ Birth Date: _____/_____/_____

Patient Name: _____

Last First MI

Phone (Home): _____ (Cell) _____ (Work) _____

Email Address _____

Address: _____

Insurance: _____

Company Employer

Please list all current medications (include vitamins and store bought medications)

_____

_____

Are you required to premedicate with antibiotics prior to dental treatment, due to joint replacement surgery or another reason _____? If so, what medication does your doctor prescribe?

_____

Are your currently pregnant or trying to get pregnant? YES NO Due Date: _____

Tobacco Use- Cigarettes/ Vaping/ E-Cig/ Other: _____ How often: _____ Use: Current/ Past

Check all that apply:

- ☐ Acid Reflux/ Gerd
- ☐ AIDS
- ☐ **Allergic to**
- ☐ Amoxicillin. ☐ Codeine
- ☐ Latex ☐ NSAIDs
- ☐ Penicillin ☐ Sulfa
- ☐ Other_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints (where)_____
- ☐ Asthma (last attack)_____
- ☐ Blood Disease
- ☐ Cancer (type)_____
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Easy Bruising
- ☐ Eating Disorder (type) _____
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (type)_____
- ☐ HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Radiation (where)_____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery (type)_____
- ☐ Thyroid Disease
- ☐ Tuberculosis (when)_____
- ☐ Tumors
- ☐ Ulcers
- ☐ Vertigo
- ☐ Venereal Disease
- ☐ **Other** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment, without fail.

Signature: _____ Date: _____

General Insurance Consent Form

As a courtesy, we submit insurance claims for our patients. The patient portion of your dental services is ***estimated and due at the time of service***. This amount is subject to adjustment when the services or claims are paid by your insurance company. In addition, certain insurance companies have annual limitations for the number of dental services that can be reimbursed and for the amount they pay out per calendar year.

You, as a patient and/or legal guardian of a patient, are responsible for monitoring your insurance coverage. If for any reason your insurance does not pay the amount estimated at the time of service, ***you are responsible for the balance.***

Please sign below to acknowledge that you have read and understand the above statement.

_____

Print Patient Name Here

_____

Patient/Legal Guardian Signature Date

Oak Ridge DENTAL ARTS

Acknowledgement of Receipt of Notice of Privacy Practices

Please read over attached Notice of Privacy Practice before signing below. You may refuse to sign this acknowledgement.

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

Patient Name _____

Patient Signature _____ Date _____

Once this page has been signed, it will be placed in your records as written acknowledgement of receipt of the Notice of Privacy Practices.

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Authorization for Release of Information

Our office is authorized to release protected health information about patient named above to the entities below. If none, please write NONE and sign & date.

Name	Relationship	Information to be disclosed	
_____	_____	Dental	Financial
_____	_____	Dental	Financial
_____	_____	Dental	Financial

Patient Signature _____ Date _____

General Dental Treatment Consent Form

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include, but is not limited to, one or several the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.)
- Treatment of diseased or injured oral tissues (hard and/ or soft)
- Treatment of malposed (crooked) teeth and/ or developmental abnormalities
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal

Risk of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks, and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours, or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change and/ or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/ all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. In the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crowns (Caps), Bridges and Onlays

I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size, and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose, based on adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general treatments and/ or proposed treatment.

Patient/ Guardian Name (printed) _____

Patient/ Guardian Signature _____ Date _____