Confidential Dental and Medical History

Patient's Name _____ Age_____ Date of Birth _____

Address _____ City, State, Zip_____

Home Phone _____ Cell _____

Work Phone _____ E-mail _____

Best Contact: ☐ **EMAIL** ☐ **CELL** ☐ **TEXT** ☐ **HOME** Best Time to Reach You: _____

SS# _____ Marital Status: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED**

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Do you have dental insurance? ☐ **YES** ☐ **NO** If YES, Insurance Carrier's Name _____

Group # _____ Phone _____ Subscriber's Name _____

Relation to Patient _____ Subscriber's SS# _____ Subscriber's Date of Birth _____

Employer/Co. Name _____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address,City,State,Zip _____

HOW DID YOU HEAR ABOUT US ? _____

Would you like to receive appointment reminders via text message? ☐ **YES** ☐ **NO**

Would you like to become friends with Carlson Dental Group on facebook.com to receive special offers? ☐ **YES** ☐ **NO**

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Carlson Dental Group at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

Carlson Dental Group

We Take The Fear Out Of Dentistry.

904.262.8409 P

Bartram Office
13241 Bartram Park Blvd.
Bldg. 1700
Jacksonville, FL 32258

Riverside Office
501 Riverside Ave.,
Suite 104
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info@CarlsonDentalGroup.com

Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

	YES	NO
Have you taken any prescription drugs during the last 6 months? PLEASE LIST.	☐	☐
_____		
_____		
Are you taking any over the counter medications or herbal supplements? PLEASE LIST.	☐	☐
_____		
Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? PLEASE LIST.	☐	☐
_____		
Any surgeries and/or hospitalizations? PLEASE LIST. _____		
Have you ever had any excessive bleeding requiring special treatment? PLEASE LIST. _____	☐	☐
Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? PLEASE LIST. _____	☐ ☐	☐ ☐
Have you ever been told to take antibiotics prior to dental treatment? PLEASE LIST. _____	☐	☐

Use of alcohol: ☐ YES ☐ NO | ☐ DAILY ☐ WEEKLY ☐ MONTHLY Use of recreational drugs: ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO What type and how much per day? _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ LOW BLOOD PRESSURE	☐ KIDNEY PROBLEMS	☐ SEIZURES / EPILEPSY	☐ LEUKEMIA
☐ HIGH BLOOD PRESSURE	☐ SEXUALLY TRANSMITTED DISEASES	☐ ALLERGIES / SINUS TROUBLE	☐ BRUISE/BLEED EASILY
☐ HEART DISEASE / ATTACK	☐ ACID REFLUX	☐ ASTHMA / BRONCHITIS	☐ OSTEOPOROSIS
☐ ANGINA PECTORIS	☐ ULCERS	☐ EMPHYSEMA / COPD	☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE	☐ LIVER FAILURE	☐ CHEMOTHERAPY	☐ JOINT REPLACEMENTS
☐ HEART FAILURE	☐ HEPATITIS / JAUNDICE	☐ RADIATION TREATMENT	☐ SLEEP APNEA
☐ HEART PACEMAKER	☐ DIABETES TYPE I OR II	☐ HIV/AIDS	☐ EXCESSIVE DAYTIME SLEEPINESS
☐ STROKE	☐ THYROID / GLAND PROBLEMS	☐ ANEMIA	

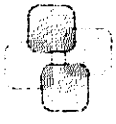
Are you pregnant now? ☐ YES ☐ NO	Practicing birth control? ☐ YES ☐ NO	Plan to become pregnant? ☐ YES ☐ NO

Emergency Contact _____ Relation _____ Emergency Phone _____

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**



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Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:	YES	NO
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
DO YOU:		
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	☐	☐
Have a hard time opening wide?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches, or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Implants
☐ Whitening ☐ Bridges ☐ Veneers ☐ Dentures ☐ Other _____

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays? _____ How often do you have dental examinations ? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric brushes, toothpick, etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

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Notice Of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 04/13/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain. Including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use or disclose your health information to a physician or healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, digital photographs, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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Acknowledgment Of Receipt Of Notice Of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

_____

_____
PATIENT OR PARENT/GUARDIAN SIGNATURE

_____ _____
PATIENT NAME **NAME OF LEGAL GUARDIAN**

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

_____

_____

****

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because _____
- ☐ Other (please describe) _____

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Cancellation Policy

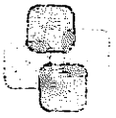
Routine appointments require a 48-HOUR advance notice to reschedule.

This will allow us time to offer your reserved appointment to someone who is waiting for an appointment and may also be in pain.

We know there are things that happen in life like flat tires, illness, and unforeseen circumstances that do come up. If you just let us know, we can help another patient with a dental emergency instead.

Thank you.

PATIENT OR PARENT/GUARDIAN SIGNATURE DATE



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Financial Arrangements

Payment is due at time of service. Patients with insurance will be expected to pay their "Estimated Patient Portion" which is calculated based upon the information we receive from the particular insurance company. This estimated amount will be due on or before the day of service. Any balance due after the insurance has paid will be billed to the patient and due within thirty (30) days of the statement date.

Appointments involving sedation must be paid in full one (1) week prior to the appointment.

Payment options:

» Cash, Cashier's Check, Personal Check

» MasterCard, VISA, Discover, American Express

» Patient Financing - We work with several financial organizations that will allow you to get the treatment you need now and spread the payments over as much as 60 months, including "no-interest" programs.

CareCredit®

So Everyone Can Have a Healthy and Beautiful Smile Today!

Our mission is to help you to achieve the best possible dental health. Our job is to evaluate the state of your oral health and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. Your job is to determine what treatment option is best for you, and the pace at which you wish to proceed with your treatment. We will gladly respect your decisions.

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