Welcome to our office!
Please print your information below:

Patient: _____ Home Phone #: (_____)_____
Last Name First Name Middle Initial

Street Address:_____ City:_____ State:_____ Zip:_____

E-mail:_____@_____.com Cell Phone #: (_____)_____

Male☐ Female☐ Date of Birth:_____ Married☐ Widowed☐ Single☐ Partnered☐ Minor☐

Responsible Person (if under 18 only):_____ Employer:_____

Are you the Insurance Policy Holder: Yes☐ No☐ If no, name & date of birth of policy holder:_____

Insurance Company:_____ Emergency Contact Name & Phone #:_____

How did you hear about our office? ZocDoc☐ 1-800-Dentist☐ Website☐ Flyer in Mail☐ Walk-by☐ Insurance Company☐

Meet & Greet☐ Staff Member☐ Internet☐ Yellow Pages☐ Yelp.com☐ Existing Patient? Name:_____

Medical and Dental History

General Physicians Name:_____ **Date of Last Physical:** _____

MEDICAL CONDITIONS: PLEASE CHECK ALL THAT APPLY:

☐ Seasonal allergies	☐ Chronic Diarrhea	☐ High Blood Pressure	☐ Respiratory Disease
☐ Arthritis	☐ Circulatory Problems	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Artificial Valves/Screws/Joints	☐ Cold Sores/Fever Blisters	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Back Problems	☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Special Diet
☐ Bleeding Abnormally	☐ Diabetes	☐ Nervous Problems/Anxiety	☐ Stroke
☐ Blood disease	☐ Epilepsy	☐ Pacemaker	☐ Swollen Neck Glands
☐ Cancer: Type:_____	☐ Headaches	☐ Psychiatric Care	☐ Ulcer
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Problems	☐ Recent Weight Loss	☐ Asthma

Are you currently under the care of a physician? Yes☐ No☐ If yes, why? _____

_____

List all medications/supplements that you are currently taking:_____

_____

Have you ever had an adverse reaction to any medication or anesthesia? Yes☐ No☐ If yes, what happened? _____

_____

Have you ever responded adversely to medical or dental treatment? Yes☐ No☐ If yes, what happened? _____

_____

Check ANY of the following that you ARE allergic to: METAL:☐ LATEX:☐

When was your last dental visit? (MM/YYYY) _____/_____ Date of your last cleaning (MM/YYYY) _____/_____ Unsure☐

Do you have any dental concerns that you would like to address?_____

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

Do you suffer from sleep apnea? Yes☐ No☐ Unsure☐ Do you grind your teeth at night? Yes☐ No☐ Unsure☐

WOMEN ONLY

Are you taking birth control pills? Yes☐ No☐ Are you pregnant or suspect that you might be? Yes☐ No☐

Are you currently breastfeeding? Yes☐ No☐

Cancelation and Late Arrival Policy Acknowledgment:

CANCELATIONS: I understand that, in order to respect my time, the time of other patients, and the staff: WE REQUIRE AT LEAST 24 HOURS WORTH OF NOTICE FOR ANY CANCELATIONS; if there is no answer if I call, I will leave a message on the office voicemail. I understand that failure to give Miswak Dentistry AT LEAST 24 hours worth of notice will result in the following fees **per patient**: The first broken appointment will be a $25 fee. The second will be a $50 fee. The third will be a $100 fee and possible dismissal.

Signature: _____ **Date:** _____

LATE ARRIVALS: I understand that if I am going to be late to an appointment, I must call Miswak Dentistry as soon as I am aware. If I am more than 15 minutes late to my scheduled appointment time, I understand that I may be asked to reschedule.

Signature: _____**Date:** _____

Consent and Acknowledgement of Policies

Please Read and Initial the Following Statements:

1. CONSENT FOR TREATMENT: I give Miswak Dentistry permission to complete my exam, necessary x-rays, cleaning, and any other dental procedures with the understanding that a staff member will go over all steps/options/treatment prior to beginning any procedure. I understand that it is my responsibility to ask for additional clarification if it is needed. Initials: ☐

2. DRUGS AND MEDICATIONS: I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have fully disclosed ALL medications that I am taking as well as my medical history to the best of my knowledge. I understand that it is my responsibility as the patient to update the office on any changes in my medical condition or medications. Initials: ☐

3. CHANGES IN THE TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the doctor to make any/all changes and additional as necessary. The doctor will always explain any changes in your treatment. Initials: ☐

CONFIDENTIAL COMMUNICATIONS: I give Miswak Dentistry permission to communicate with me using the information that I have provided on this form. If my phone number, address, or e-mail addresses change at all while I am a patient at this office: It is MY responsibility to update the office accordingly. If I do not want Miswak Dentistry to contact me using the information provided, I will provide an alternative address, phone number, and e-mail address if applicable. Initials: ☐

5. PAYMENT AND INSURANCE CLAIMS: I understand that payment is due at the time of service unless an alternative arrangement has been made with the office. I understand that any treatment plan proposed by the staff at Miswak Dentistry is an estimate of what my insurance should cover, and if for ANY reason my insurance pays less; I will be responsible for ANY balance left unpaid by the insurance company. Initials: ☐

Acknowledgement of the Receipt of Privacy Policy

You may refuse to sign this acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. A more detailed Privacy Policy is available at your request at the front desk. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple health care provides who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers.
3) Conduct normal health care operation such as quality assessments and physicians certifications.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to changes its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bond to abide by such restrictions.

Patient Name:_____ Relationship to patient (if under 18 years old only)_____

Signature:_____ Date:_____