

Dr. Mr. Mrs. Ms. _____ Date of Birth _____
(Last) (First) (initial)

What is your general state of health? Excellent Good Fair Poor

◇Primary Physician _____ ◇Specialist (type) _____ ◇Specialist (type) _____
 Name _____ Name _____ Name _____
 Address _____ Address _____ Address _____
 Phone # _____ Phone # _____ Phone # _____

Have you been under a physician's care during the last two years? _____
 Have you been treated in a hospital in the past three years? _____
 Have you had major surgery? _____
 History with general or IV anesthesia? _____
 Have you ever taken drugs for osteoporosis/penia? _____
 If female: Are you pregnant or nursing? _____
 Do you have any food allergies? _____
 Has it ever been recommended that you take antibiotics prior to dental visits? _____

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

	Present	Past	None		Present	Past	None		Present	Past	None
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia / Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Penia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis / PPD+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Novocain Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problem / Bruises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A,B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any condition, disease or problem not previously listed? _____								Latex Allergy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Are you allergic to any medications not listed above? If so which: _____

Please list all the medications you are taking, including over the counter drugs and herbs:

Medications	Dosage / Day	Reason

Signature of patient/parent/guardian _____ Date _____

CONTACT INFORMATION

Dr. Mr. Mrs. Ms. _____ Preferred Name _____ Sex: M / F
(Last) (First) (initial)

Cell # () _____ Home # () _____ Work # () _____ - _____ Ext () _____

Social Security# _____ Email Address _____

Preferred Number cell home work Marital Status _____ Spouses' Name _____

Address: _____
Street Apartment #

_____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Emergency Contact _____ Emergency Contact # () _____
(Last) (First)

REFERRAL INFORMATION

How did you find out about our office? _____

Who may we thank for referring you to our practice? _____

Reason for choosing Noll Family Dentistry? _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name _____ Sex: M / F Relationship to Patient _____
(Last) (First) (initial)

Address _____
Street City State Zip Code

Cell# _____ Home# _____ Work# _____ Ext _____ Email _____

INSURANCE INFORMATION

Primary Carrier

Insured Name _____
 Birthday _____
 Insured's Employer _____
 Insured Soc. Sec. # _____
 Group # _____
 Insurance Company _____
 Insurance Co. Address _____

 Insurance Co. Phone # _____

Secondary Carrier (If you have double coverage)

Insured Name _____
 Birthday _____
 Insured's Employer _____
 Insured Soc. Sec. # _____
 Group # _____
 Insurance Company _____
 Insurance Co. Address _____

 Insurance Co. Phone # _____

Our goal is to provide you with extraordinary care and service. Is there anything we can do to give you the best experience?

 Signature of patient, parent or guardian Date _____ Relationship to Patient _____

Dr. Mr. Mrs. Ms. _____ Date of Birth _____ Sex: M / F
(Last) (First) (initial)

DENTAL CONCERNS & PREFERENCES

What are your primary dental concerns? _____

Importance of Each: circle on a scale of 1 (lowest) to 5 (highest)

Preventative Care	1	2	3	4	5	Cost & Affordability	1	2	3	4	5
Overall Wellness	1	2	3	4	5	Appearance of Smile	1	2	3	4	5
Extraordinary Service	1	2	3	4	5	Extraordinary Quality of Treatment	1	2	3	4	5
Freedom from Pain	1	2	3	4	5	Avoiding Dentures / Removable Teeth	1	2	3	4	5

When discussing treatment I prefer (circle): BIG PICTURE or DETAIL BY DETAIL

Do you feel nervous about dental treatment? YES or NO

Have you had a bad dental experience? YES or NO If yes describe _____

Is there something we can do to make you more comfortable? _____

DENTAL HISTORY

When was your last dental visit? _____	Sensitive Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason for visit? _____	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of previous dentist _____	Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location (City / State) _____	Loose Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last exam _____	Clenching / Grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last xray(s) _____	Orthodontic Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of most recent treatment _____	Perio Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AESTHETICS

Smile aesthetics expectations: LOW / MEDIUM / HIGH

Are you happy with your smile? YES or NO

What would you change? _____

	<small>Present</small>	<small>Past</small>	<small>None</small>
Smoking / Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Surgery / Extractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Freq. Sugary Drinks/ Juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TMJ

Have you ever been diagnosed with a problem with either jaw joint? YES or NO

Does your jaw click, pop, or make noise when you open or close? YES or NO

Has your jaw ever locked open or closed? YES or NO

Do you get headaches? If so how often or when? YES or NO If yes _____

Do you clench or grind your teeth or been told that you do? YES or NO

Do you have a history of trauma to your chin or jaw? YES or NO

Have you worn a nightguard? YES or NO

SLEEP

Have you ever been diagnosed with sleep apnea? YES or NO

Do you wear a CPAP or dental appliance? YES or NO If yes what _____

Do you snore? YES or NO

RELEASE & PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

Noll Family Dentistry is dedicated to improving standards of care through the delivery of extraordinary treatment, research and sharing of expertise. This photo release allows us to lecture, teach, publish and learn in the pursuit of dental excellence. If you have any questions or concerns with this agreement please feel free to discuss them with a treatment coordinator or your dentist prior to signing.

Patient Name

This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between DENTIST/PRACTICE and PATIENT in connection with the medical services PATIENT received from DENTIST / PRACTICE.

DENTIST / PRACTICE and PATIENT warrant and represent that PATIENT has given CONSENT and FULL AUTHORIZATION that any photographs and/or images of PATIENT, under the following conditions.

1. The photographs and/or images & videos will be taken by DENTIST/PRACTICE or by a photographer and/or skilled operator approved by DENTIST/PRACTICE.
2. The photographs and/or images may be used for:
 - a. Identification purposes, medical records, and if in the judgment of DENTIST/PRACTICE, medical research, education or science will be benefited by their use. Such photographs and/or images and information relating to PATIENT may be published or republished, either separately or in connection with each other, in but not limited to, professional journals, medical books, medical based Internet websites, or any other purpose which DENTIST / PRACTICE may deem proper in the interest or, but not limited to, medical education, knowledge, or research; and or
 - b. PATIENT further authorizes that the photographs and/or images may be used by DENTIST/PRACTICE or by an entity approved by DENTIST/PRACTICE in promotional printed, computer website and / or video material.

OK to use full face images for promotional & video material
 Please refrain from using full face images in promotional material

3. At no time will PATIENT'S name, address, or any other alpha/numeric PATIENT identifiable information be used in connection with the publication of the photographs and / or images of PATIENT. PATIENT acknowledges the possibility that his/her identity may become known as a result of the publication and use of the photographs and / or images described in paragraph 2; above.

4. The photographs and / or images & video may be modified and / or retouched in any way in DENTIST'S / PRACTICE discretion.

By signing below, PATIENT certifies that he / she has read and understood each and every section of this Agreement, and agrees to be bound by its terms.

PATIENT

DATE

WITNESS

DATE

INSURANCE AGREEMENT

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance. We realize how confusing it can be. To begin, we would like to highlight a misconception--dental insurance is not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment. However, at Noll Family Dentistry we are committed to working with you and your insurance company in order to provide the best and most affordable treatment.

All levels of payment by insurance companies, including allowed fees and UCR's (usual and customary rates), are governed by the premiums they are paid. They do not reflect actual dental costs. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on the restraints of your insurance contract.

It should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility. All estimated co-pays for treatment performed at our office is due at the time of service.

We hope this information has been helpful. Please take the time to review your insurance contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Patient Name (Printed)

Date

Patient Signature

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I had the opportunity to review and/or obtain a copy of this office's Notice of Privacy Practices.

Print Name: _____ Date of Birth: _____

Signature: _____

Relationship to patient (if signed by personal representative of patient): _____

Date: _____

Please check the box if we are able to leave a message with medical & financial information on phone numbers

Please list individuals names that we are allowed to release financial and medical information to:

1 _____ 2 _____

** You May Refuse to Sign This Acknowledgment**

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### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Noll Family Dentistry– Consent to treat a minor/child**

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, our office staff will be delighted to help you.

1. I hereby authorize and direct doctors and staff at Noll Family Dentistry to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. I understand certain parts of the treatment may be performed by dental assistants and hygienists.
2. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor, but copies are available upon request.
3. In general terms, the dental procedure(s) can include but not be limited to comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride, application of sealants to the grooves of the teeth, treatment of diseases or injured teeth with dental restorations, stainless steel or composite crowns and/or root canal treatment, oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, exposure of unerupted tooth, placement of space maintainers and/or replacement of missing teeth with dental prosthesis, treatment of diseases or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection, treatment of habits, malposed (crooked) teeth, orthodontics and/or oral dental development or growth abnormalities
4. I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child. I understand that the doctor is not responsible for previous dental treatment. I understand that in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
5. I have answered all the questions about my or me dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should receive oral medications. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s) I will inform the doctor at the next appointment.
6. I authorize other individuals with whom I have placed the care of my child, such as other family members, caregivers to sign consent for dental treatment for my child should they bring my child to any future appointments.

I hereby acknowledge that I have read & understand this consent and the meaning of it's contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_