



PROSTHODONTIC ASSOCIATES

Specialists in Restorative Dentistry

Est. 1970

Patient Information

Patient Name: _____ I prefer you call me: _____

First Middle Last

Male: Female: Single: Married: Divorced: Widowed: Other:

Phone-Home: (____) _____ Cell: (____) _____ Work: (____) _____ Ext: _____

My preferred Contact phone number is: Home: Cell: Work: Birthdate: ____/____/____ Age: _____

Street Address: _____ Apartment# _____

City _____ State _____ Zip Code: _____ SS#: _____

Occupation: _____ Employer & Address: _____

May we leave a message with detailed information at the following #'s: Home: Cell: Work:

May we communicate when necessary with you via email? Y/N (if yes) email address: _____

Whom may we contact in case of emergency? _____ Relationship: _____

Emergency contact H: _____ Cell: _____ Wk: _____ Ext: _____

Whom may we thank for referring you to our practice? _____ & please check their

corresponding box: Referring Dentist: Another patient, friend or relative: Website/search: Yellow Pages:

Spouse Information

Spouse's Name: _____ Birthdate: ____/____/____

First Middle Last

Phone- Cell: (____) _____ Work: (____) _____ Ext: _____

Employer: _____ Occupation: _____

Responsible Party

Who will be responsible for your account? Self: (if self, skip to next section) Spouse: Parent: Other:

Responsible Party Name: _____ Birthdate: ____/____/____

First Middle Last

Billing Address: _____ Apartment# _____

City _____ State _____ Zip Code: _____ SS#: _____

Phone-Home: (____) _____ Cell: (____) _____ Work: (____) _____ Ext: _____

Employer: _____ Occupation: _____

This signature authorizes the release of information to other health care providers regarding my history, examination and treatment course when applicable. It is my responsibility to inform this office of any changes to my records, medical status and insurance coverage.

For your convenience, we accept Visa, Master Card, Discover and American Express, cash and personal checks. We also offer Care Credit as an option for your care.

Patient Signature Date

I do not have any dental insurance coverage-Skip to the **last box** on this page.

For those patients having dental insurance please complete *all* the information below.

As a courtesy to you, we will file your claims to your insurance company electronically whenever possible. Electronic filing assists in a shorter turnaround of insurance benefits. Please remember that most insurance plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any portion your plan does not cover.

We encourage you to become familiar with your insurance plan-policy exclusions, deductibles. It is your responsibility to understand your plan(s) benefits. Each company varies according to the contract elected by the employer. **Please be aware that we are not participating providers with any specific dental plan.**

Primary Dental Insurance Company

Name of Policy Holder: _____ Birthdate: ____/____/____
First Middle Last

Relation to Policy Holder: Self: Spouse: Child: Other: _____

Insurance Company: _____ Insurance Company Address: _____

City: _____ State _____ Zip Code: _____ Insurance Phone:() _____

Policy Holder ID Number: _____ Group #: _____

Do you have additional dental insurance? Yes: No: If yes, complete the following box below:

Secondary Dental Insurance Company

Name of Policy Holder: _____ Birthdate: ____/____/____
First Middle Last

Relation to Policy Holder: Self: Spouse: Child: Other: _____

Insurance Company: _____ Insurance Company Address: _____

City: _____ State _____ Zip Code: _____ Insurance Phone:() _____

Policy Holder ID Number: _____ Group #: _____

Authorization & Release

To assist us in obtaining your benefits, please sign the "Assignment of Benefits" below to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Prosthodontic Associates to release to my insurance company, information acquired in the course of dental care to assist in the processing of claim(s) for the insured having coverage through my plan policy. This signature on file is my authorization for the release of information necessary to process my claim(s) and release information to other health care providers regarding my history, examination and treatment course. I also authorize benefits to be paid directly to the doctor (except for those plans that pay the patient directly when seeing a non-participating doctor). I understand that I am responsible for any unpaid balance on my account. It is my responsibility to inform this office of any changes to my records, medical status and insurance coverage.

Signature of patient/policy holder

Date

Are you in good health Y/N --- Are you under the care of a physician at this time? Y/N Date of last visit: _____

Name of physician: _____ Phone#: _____ Treated for: _____

Have there been any changes in your general health over the past year? Y/N (if yes) _____

Do you or have you taken any of the following: Phen-Fen: Redux: Oral bone density medications containing bisphosphonates (such as Fosamax, Actonel or Boniva): Intravenous bisphosphonates (such as Reclast, Zometa, Aredia or Bonafos): No to all:

MEDICAL & DENTAL QUESTIONNAIRE

Mark your response to indicate if you have had any of the following diseases or problems. If you are unsure then mark don't know (DK). Please use the space provided to further explain any medical conditions.

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Cardiovascular</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet/ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina (chest pain)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged heart valve
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bacterial endocarditis (heart infection)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart transplant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic (artificial) heart valve
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular graft
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular stent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defect

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Hematologic</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal or Excessive bleeding

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Respiratory</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD ___Emphysema ___Chronic Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other sleep disorder _____

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Endocrine</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemic (low blood sugar)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Skin</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other skin lesions _____

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Immune</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppressed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjogrens's Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Past steroid usage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delayed healing

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Gastrointestinal</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/GERD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal disease _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Musculoskeletal</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Osteo_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint (s) Type_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of placement: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-medication required by physician for joint replacement? Yes___ No___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Hepatic</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease-Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type_____

<u>Yes</u>	<u>No</u>	<u>DK</u>	<u>Neurologic</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures Due to injury? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic brain injury (concussion)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TIA (transient ischemia attack)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke

DENTAL INFORMATION

What is the reason for your dental visit today? _____
My current dental health is? Good: Fair: Poor:
How often do you brush your teeth? ____/day how & often do you floss? _____
Who is your previous dentist present dentist: _____
When was your last dental visit: _____

Yes No

- Is it important for you to keep your teeth?
- Are you satisfied with the appearance of your teeth?
- Are you satisfied with the function of your teeth?
- Does food frequently get caught between teeth?
- Do your gums often bleed while brushing?
- Have you noticed loosening of your teeth?
- Have you injured your head, neck, or jaw?
- Do you have difficulty eating or swallowing?
- Do you have a dry mouth?

Yes No

- Have you noticed clicking of the jaw?
- Do you have pain in joint, ear side of face? (circle any that apply)
- Do you have difficulty opening or closing your jaw?
- Do you have difficulty chewing?
- Do you clench or grind your teeth?
- Do you bite your lips or cheek frequently?

Yes No Have you had:

- Orthodontic treatment (braces)?
- Oral surgery?
- Perio surgery (gum surgery)?
- Your bite adjusted?
- A bite plane/guard or other appliance?
- A change in your ability to taste foods?

Yes No Do you currently have:

- Dental Pain?
- Sores or swelling in your mouth?
- Bad breath?
- Broken fillings?
- Sensitivity to Cold Hot Sweets Biting down?
- Do you supplement your diet with fluoride?
- A partial denture?
- A full denture?
- Dental implants?
- Have you had any difficulty with dental treatment? Please explain: _____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

PROSTHODONTIC ASSOCIATES

Consent for use and disclosure of health information

Section A: Patient Giving Consent

Name: _____
Address: _____
Telephone: _____ E-mail: _____

Section B: To the Patient-Please Read the Following Statements Carefully

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of you protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent upon request. We encourage you to read it carefully and completely before signing this.

We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will containing the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Diane Cunningham, Practice Manager 651-633-4914 or manager@pros-specialists.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ am aware of Prosthodontic Associates' Notice of Privacy Practices
Print Name (a copy is available upon request and is posted is available in the reception area)

Request for Family member to have access to protected health information

The name(s) listed below are family member(s), friend and/or personal representative to whom I wish to grant access to my healthcare information. I hereby authorize Prosthodontic Associates to disclose my Protected Health Information (PHI) including appointment and billing information to the following:

Name	Relationship to Patient
1. _____	_____
2. _____	_____

None

I understand this consent will be considered valid until such time I revoke it. I may revoke this authorization by sending a written request for revocation to Prosthodontic Associates. I understand the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I have read each section above and agree to these terms.

Patient /Personal Representative Signature

Date

If this consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's name

Relationship to patient