PATIENT INFORMATION FORM

Patient's Name _____ ***Today's Date:*** _____

Gender: **Male:** ☐ **Female:** ☐ **Birthdate:** _____ **Social Security #:** _____

Address:

_____

City: _____ **State:** _____ **Zip-Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Marital Status:** _____

Patient Email:

_____

Emergency Contact: _____ **Emergency Contact Phone #:** _____

Medical Clinic: _____ **Location** _____ **Physician Name:** _____

Preferred Pharmacy:

_____

Insurance Information

This section must be completed if we will be billing for you.

Primary Insurance Company _____ **Card Holder Name:** _____

Patient's Relationship to Insured:

Self ☐ **Spouse** ☐ **Child** ☐

Member ID: _____ **Card Holder SS#:** _____ **Card Holder DOB:** _____

Employer:

_____

☐ **Initial for consent to release medical/dental records from a previous office.**

☐ **Initial for Office Policy Acknowledgment**

****Written Office Policy is available upon request and is also available online***

Print Name: _____

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

PATIENT MEDICAL INFORMATION FORM

Medical Conditions:

Y	N	
☐	☐	Blood Disorder/Anemia
☐	☐	Unexplained Bleeding or
☐	☐	Bruising Taking Blood Thinner
☐	☐	Angina Pectoris
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery/Stents
☐	☐	Pacemaker
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Bisphosphonate Use
☐	☐	Need to take Premed?
☐	☐	Stroke
☐	☐	Breathing/Lung Issues
☐	☐	Asthma
☐	☐	Sinus Problems
☐	☐	Seasonal Allergies
☐	☐	GI Issues

Y	N	
☐	☐	GERD/Acid Reflux
☐	☐	Alcohol/Drug Use
☐	☐	Cancer/Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Depression or Anxiety
☐	☐	ADD/ADHD
☐	☐	Diabetes
☐	☐	Glaucoma
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	HIV + AIDS
☐	☐	Hepatitis B/C
☐	☐	Special Needs
☐	☐	Sleep Disorder/CPAP Use
☐	☐	Seizure Disorder
☐	☐	Thyroid Problems
☐	☐	Frequent Headaches
☐	☐	Persistent Cough
☐	☐	Cold or Flu Symptoms
☐	☐	Recent Surgery/Hospitalization
☐	☐	Have had Covid-19

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?
☐	☐	Do you vape or use an e cig?

Weight: _____ **Height:** _____

If female, please answer the following:

Y	N	
☐	☐	Are you pregnant?

If Yes, # of weeks _____

Y	N	
☐	☐	Are you nursing?

Allergies

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other:

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe:

Please list any MEDICATIONS, vitamins, supplements, or homeopathic therapies that you are currently using:

I certify this information is complete and accurate.

Print Name: _____ **Date:** _____

Signature: _____

Relationship to Patient ☐ **Self** ☐ **Parent** ☐ **Legal Guardian**

For Office Use Only

Blood Pressure: _____

Heart Rate: _____ **Temp:** _____

PATIENT DENTAL INFORMATION FORM

Y/N Dental Questions

Y N

☐☐ Do you have current pain in teeth or gums?

☐☐ Do you have bleeding/sore gums?

☐☐ Do you have bad breath?

☐☐ Do you have loose/shifted teeth?

☐☐ Do you have broken/chipped teeth?

☐☐ Do you have missing permanent teeth?

☐☐ Do you have sensitive teeth?

☐☐ Do you experience dry mouth?

☐☐ Do you have trouble getting numb?

☐☐ Do you consume soda/energy drinks frequently?

☐☐ Do you have pain in your jaw joint(s)?

☐☐ Do you have clicking/noise in your jaw joint(s)?

☐☐ Do you clench or grind your teeth?

☐☐ Do you snore?

☐☐ Do you have a history of orthodontic treatment (braces)?

☐☐ Do you wear retainers?

☐☐ Do you have dental implants?

☐☐ Do you have a history of jaw or face surgery?

☐☐ Do you have a history of gum treatments or surgery?

☐☐ Do you wear dentures or partials?

☐☐ Are you happy with the appearance of your teeth?!

☐☐ Would you like straighter teeth?

☐☐ Would you like whiter teeth?

☐☐ Do you have dental anxiety that prevents you from seeking regular dental care?

How long ago was your last dental visit?

How often do you brush your teeth?

How often do you floss your teeth?

Please explain any **yes** answers from the Dental Questions section in the space provided below.

I certify that this information is complete and accurate.

Print Name:

Patient/Guardian Signature:

Date:

Acknowledgment and receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

Patient Name **Patient Date of Birth**

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I have received a copy of Sparta Dental, SC's Notice of Privacy Practices (available upon request or on our website at www.spartadental.com). I understand that this office may change the terms of its notice, and make the new notice provisions effective for all protected health information that it maintains.

I authorize Sparta Dental Center, SC and any of its employees to disclose and discuss my patient health care records (including the diagnosis, records, examination, and treatment rendered), billing, and insurance claim information to the following persons, including those involved in my care or payment for that care:

Name: Relationship to Patient:

Name: Relationship to Patient:

Name: Relationship to Patient:

I understand that this consent is effective until revoked by me. I understand that I may revoke this consent at any time by giving written notice of revocation to Sparta Dental Center, SC. Revocation of this consent will not affect any action that was taken in reliance on this authorization before written notice of revocation was received.

I understand that I have the right to receive a copy of this authorization.

I, (please **print** name of person signing)

am confirming my written permission for the disclosure of my protected health information, as described in this form and in the Privacy Practices of Sparta Dental, SC.

By refusing to sign this acknowledgment we are unable to submit your dental claims to your insurance or communicate to health care facilities on your behalf.

Signature of *patient* or *parent* if under the age of 18:

Date:

Relationship to Patient: **Self:** **Parent:** **Legal Guardian:**

For office use only
We could not obtain written acknowledgment because:

__ Individual refused to sign.
__ Communication barriers prevented us from obtaining a signature.
__An emergency situation prevented us from obtaining a signature..

SPARTA DENTAL CENTER

PATIENT: _____ DATE _____

It is the policy of **Sparta Dental Center** to inform parents of all recommended procedures for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, extractions, etc., will be performed at a separate appointment after obtaining your permission.

1. I hereby authorize Dr. Knoll and staff to perform the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures or operation may include:(Please Initial every one)

_____ A. Cleaning of the teeth and exam

_____ B. Topical application of fluoride

_____ C. Application of sealants to the grooves of the teeth.

_____ D. Treatment of the decayed or injured teeth with a dental restoration

_____ E. I elect resin (white) / amalgam(silver) (**circle one**) for posterior (back) teeth.
Resin will be done on all Anterior (Front) teeth.

_____ F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts 1-3 hours.**Please do not tell your child they are going to get a "shot" we have special ways of informing them to ease anxiety.**

_____ G. **I further understand that parents and family members will be asked to remain in the reception area so that Dr. Knoll and staff can focus entirely on your child.**

_____ H. Restraints will not be used! If a patient is uncooperative he/she will be dismissed for the day. (A referral to a pediatric dentist or mild sedative may be prescribed)

_____ I. I understand that insurance may not cover any or all of the above procedures, and I am responsible for any amount not covered by insurance on the day of service.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP TO PATIENT

This authorization will remain in effect until changes are made by the parent/guardian as signed above or until patient becomes 18 years old.

In my absence, I hereby give authorization for the person listed below to bring my child to Sparta Dental Center and to consent for any and all recommended dental services.

Legal guardian must bring child to first dental appointment.

_____ Relationship to child: _____