PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL ADDRESS _____ CELL PHONE _____

SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN OFFICE PHONE DATE OF LAST EXAM

	YES	NO
1. Are you under medical treatment now?		
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking?		
4. Have you ever taken Fen-Phen/Redux?	❑	❑
5. Do you use tobacco?	❑	❑
6. Do you use alcohol, cocaine or other drugs?	❑	❑
7. Are you wearing contact lenses?	❑	❑

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Local anesthetics (eg. novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicllin or other antibiotics	❑	❑	Sedatives	❑	❑	Other
❑	❑	Sulfa Drugs	❑	❑	Iodine			

	YES	NO
9. Do you have'a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
10. WOMEN ONLY:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

11. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever / Allergies
❑	❑	Fainting / Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
		Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Disease	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease			Other
❑	❑	Thyroid Problem	❑	❑	Stomach Troubles / Ulcers			

_____ _____

Signature of Dentist Date

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) Difficulty in chewing?	❑	❑

	YES	NO
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you had any orthodontic work?	❑	❑
13. Have you ever had prolonged bleeding following extractions?		
14. Have you ever had Instruction on the correct method of brushing your teeth?	❑	❑
15. Have you ever had instructions on the care of your gums?	❑	❑

I certify that I have read **and** understand the above Information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing Incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager.

Home Phone: _____ Work Phone: _____ Ext: Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

-Patient Information -

Address: Address 2:

City: State / Zip: Pager.

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Ins. Group #: _____

Referred by:: _____

Last Dentist': _____

Last Dental Visit: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer. _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer. _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct _____ .00

Patient Full Name:_____

Date:_____

Financial Policy

Please read the terms of our financial policy below. Your signature below indicates you understand and agree with this policy.

1. Payment for services is due at the time services are rendered unless prior arrangements have been made. Any payment owed will be collected prior to being seen by your provider.

2. We accept the following forms of payment: Cash, Check, Credit Cards (Visa, MasterCard, Discover and American Express) and Debit Cards.

   a. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

3. In addition, we offer CareCredit & Lending Club, both patient payment programs, providing a full range of No Interest and Extended Payment Plans for all patients and treatments.

4. No refunds will be issued once treatment plan has been approved and commenced.

5. We accept most dental insurances:

   b. Please note that having active insurance coverage does not mean a guarantee of payment in full. Payment will be determined at the time the claim is processed by your insurance carrier.
   c. YOU ARE RESPONSIBLE for any amount not covered by your dental plan, such as, deductibles, co-payments and additional services. These are due at the time of treatment.

6. National Dental also offers the NATIONAL DENTAL MEMBERSHIP PLAN designed for your specific needs. Be sure to ask a National Dental team member how you and your family can benefit from this program.

_____

Signature of Patient or Responsible Party Witness Signature Date

GENERAL CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of National Dental PLLC. to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids:
   - ➢ Consult with examination for future treatment.
   - ➢ Preventive hygiene treatment (prophylaxis), and the application of topical fluoride. ➢ Application of plastic "sealants" to the grooves of the teeth.
   - ➢ Treatment of diseased or injured teeth with dental restorations (fillings, crowns, and onlays). ➢ Treatment of diseased or injured teeth with endodontic (root canal) therapy if needed.
     **Breakage of dental instruments inside tooth canals requiring additional treatment.
   - ➢ Replacement of missing teeth with dental prostheses (i.e. implants, bridges, partials, and full dentures). ➢ Removal (extraction) of one or more teeth.
     **Involvement of the nerves during oral surgery or administration of local anesthesia resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas of the face or neck.
     **Sinus involvement during the removal of upper molars, which may require additional treatment or surgical repair at a later date or by an oral surgeon.
     **Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, occasionally small root tips may be left in place.
     'Jaw fracture- While quite rare, it is possible in difficult or deeply impacted teeth.
   - ➢ Treatment of diseased or injured oral tissue (hard and/or soft).
   - ➢ Use of sedative drugs to control apprehension and/or disruptive behavior.
   - ➢ Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
2. I understand that there are risks involved in this treatment, and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well-being, in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose, which disappears shortly after procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctor to use anonymized photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Print Patient's Name **Print Name of Parent or Guardian (if applicable)**

Signature of Patient or Parent/Guardian **Date** **Witness Signature** **Date**