Patient Information Form

For the offices of

Dr. Jonathan A. Morris

In order to provide you with thorough and comprehensive dental care the following information is requested. All disclosed information will be kept confidential according to the rules and guidelines of H.I.P.A.A.

PLEASE PRINT

Patient Information

Patient Name _____ (Last) (First) (Title) (MI) (Preferred Name)

Social Security # _____ Birth Date _____ Gender (M/F) _____ Marital Status _____

Home Address _____ (Street Address) (City) (State) (Zip code)

Phone numbers _____ (Home) _____ (Work (+ ext.)) _____ (Cellular) _____ (E-Mail Address)

Employer _____ (Company Name) (City/State) (Position)

Emergency Contact _____ (Name) (Relation) (Phone Number)

Who will be responsible for payment for this account? _____

Spouse Information

Spouse's Name _____ (Last) (First) (Title) (MI) (Preferred Name)

Employer _____ (Company Name) (City/State) (Position)

Referral Information

Whom may we thank for referring you to our dental practice?

- ❑ Another patient _____ (Name)
- ❑ Dentist/specialist/physician _____ (Name)
- ❑ Yellow Pages
- ❑ Other _____ (Name)

Insurance Information

Primary Insurance

Insurance Company _____ (Company Name) (Company Phone number)

Name of Insured _____ (Last) (First) (MI) (Social Security #)

Insured's Birth Date _____ ID# _____ Group# _____

Insured's Address (if different than patient) _____

Patient's relationship to insured: ❑Self ❑Spouse ❑Child ❑Other _____ (Explain)

Secondary Insurance

Insurance Company _____ (Company Name) (Company Phone number)

Name of Insured _____ (Last) (First) (MI) (Social Security #)

Insured's Birth Date _____ ID# _____ Group# _____

Insured's Address (if different than patient) _____

Please Complete Both Sides

X _____

Medical History

Pt. Name_____

Name of current physician_____ Date of last appointment_____ (Month/year)

Physician's address_____ Phone number_____

Please list all vitamins, prescription, over the counter, and homeopathic medication(s) you are currently taking and why:

_____

Please check the answer the following questions.

Yes	No	
❑	❑	Are you in good health?
❑	❑	Are you presently being treated for any condition(s) by a physician? Explain_____
❑	❑	Have you had any serious illness, operation, or been hospitalized in the past 5 years? Explain_____
❑	❑	Has anyone in your family been diagnosed with oral cancer?
❑	❑	Do you drink alcohol? _____ (How often?)
❑	❑	Do you routinely use mouth rinses? _____ (What type? / How often?)
❑	❑	Do you use tobacco products? _____ (What type? / How often?)
❑	❑	If you use tobacco products would you like help to stop?

Women only

❑	❑	Are you taking birth control pills?
❑	❑	Are you or do you suspect that you may be pregnant? Due date_____
❑	❑	Are you nursing?
❑	❑	Are you on hormone replacement therapy?

Please check all that apply

Have you ever had any of the following? ❑ To my knowledge I do not have any of the following conditions.

- ❑ AIDS
- ❑ Allergy-Aspirin
- ❑ Allergy-Codeine
- ❑ Allergy-Sulfa
- ❑ Allergy- Penicillin
- ❑ Allergy-Other Antibiotics
- ❑ Allergy Other_____
- ❑ Anemia
- ❑ Artificial joint_____
- ❑ Asthma
- ❑ Blood Disease_____
- ❑ Cancer_____
- ❑ Chemical dependency
- ❑ Chest pain
- ❑ Chronic diarrhea
- ❑ Circulatory problems
- ❑ Contact lenses
- ❑ Diabetes
- ❑ Difficulty breathing
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Head injuries
- ❑ Headaches _____
- ❑ Heart disease
- ❑ Heart murmur (MVP)
- ❑ Hemophilia
- ❑ Hepatitis_____ (type)
- ❑ Hip replacement
- ❑ HIV infection
- ❑ High blood pressure
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Knee replacement
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Nervous disorder
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Problems w/immune system
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Seizures
- ❑ Sickle cell disease
- ❑ Sinus problems
- ❑ Special diet_____
- ❑ Stomach problems
- ❑ Stroke
- ❑ Swollen neck glands
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Transfusion
- ❑ Transplant_____
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Other_____

Have you ever been told by a physician you must take pre-medication (antibiotics) before dental treatment?
Explain_____

Do you have any disease, condition, or problem not listed above that you think the doctor should know about?
Explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

X_____

Dental Information

Pt. Name _____

Please answer the following questions to help us familiarize ourselves with your dental history, current dental situation and future dental goals.

Purpose for today's appointment _____

Previous dentist _____ (Name) _____ (Address) _____ (Phone Number)

Date of last dental visit _____ (month/year) What for? _____

Date of last dental x-rays _____ (month/year) Why did you change dentists? _____

Please check the answer the following questions.

Yes	No	
☐	☐	Have you ever had an allergic reaction to latex? Describe _____
☐	☐	Have you ever had an adverse reaction to local anesthetic? (i.e. Novocaine) Describe _____
☐	☐	Do you request Nitrous Oxide during dental procedures? ☐ cleanings ☐ restorative treatment
☐	☐	Have you had any serious trouble associated with previous dental treatment? _____
☐	☐	Do you have a fear of going to the dentist? Comments _____
☐	☐	Do you have trouble eating and chewing foods satisfactorily? _____
☐	☐	Have you ever had braces or orthodontic treatment? _____
☐	☐	Have you ever had periodontal (gum) treatment? When? _____
☐	☐	Do you floss? How often? _____
☐	☐	Do you play any sports? List _____
☐	☐	Do you wear any of the following? ☐ night guard ☐ snoring device ☐ orthodontic appliance ☐ sports guard
☐	☐	Do you snore, have trouble sleeping or breathing while you sleep?
☐	☐	Have you ever whitened your teeth?
☐	☐	Are you happy with the appearance of your teeth?
☐	☐	Are you interested in information about cosmetic dental procedures?
☐	☐	Are there any specific questions you would like answered by the dentist? _____
☐	☐	Is there any dentistry that was recommended to you that has not yet been completed _____

For the following questions check all that apply.

I am currently experiencing sensitivity or pain in my head, neck, or mouth from the following: (None ☐)

☐ hot ☐ cold ☐ sour ☐ sweet ☐ chewing ☐ other _____ (explain) ☐ touch

The pain or sensitivity is: (None ☐)

☐ sharp pain ☐ dull ache ☐ constant ☐ intermittent ☐ goes away immediately ☐ lasts hours ☐ wakes you from sleep ☐ lasts days ☐ started when? _____ ☐ other _____ (explain)

Do you ever experience any of the following symptoms in or around your head, neck, or mouth?

☐ swelling ☐ blisters ☐ bleeding gums ☐ ulcers ☐ gumboils ☐ headaches ☐ jaw clicking ☐ ear aches ☐ jaw popping ☐ lumps ☐ food catching ☐ cold sores ☐ red patches ☐ white patches ☐ other _____ (explain)

I presently have in my mouth: (None ☐)

☐ silver fillings ☐ tooth colored fillings ☐ crowns ☐ fixed bridges ☐ removable partials or dentures ☐ dental implants ☐ cosmetic bonding ☐ porcelain veneers ☐ unfilled cavities ☐ inlays/onlays

I am interested in the following dental care:

☐ Complete dental care that emphasizes treating dental concerns early to prevent future problems including replacement of missing teeth, periodontal (gum) treatment and crowns where necessary.
☐ Maintenance dental care that will maintain my current dental status with tooth colored fillings and preventive maintenance.
☐ Emergency dental care to treat my present problem only.

I would prefer:

☐ fewer appointments for a longer length of time
☐ multiple appointments for shorter length of time
☐ local anesthetic for treatment
☐ medication i.e. Valium for treatment

I have or would postpone dental treatment because of the following:

☐ fear ☐ cost ☐ time ☐ lack of concern ☐ other

X _____

PRINT NAME _____

H.I.P.P.A.

Health Insurance Portability and Accountability Act

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations and referrals. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Signature/Guardian _____ Date _____

Consent Information

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. If my account becomes delinquent, I understand that one percent per month late charge plus actual and reasonable collection charges plus reasonable attorney's fees will be added when necessary to collect my delinquent account.

Signature/Guardian _____ Date _____

Insurance Assignment and Release

I certify that I am insured with _____ and assign directly to Dr. Samantha Morris all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Samantha Morris may use my healthcare information and may disclose such information to any of my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent can only be revoked with written notice to this office.

Signature/Guardian _____ Date _____

Do not sign the following section until the doctor has completed your examination and reviewed his treatment recommendations with you.

Treatment Agreement

I hereby authorize and request the performance of dental services for myself or for _____. I also give my consent to any advisable and necessary dental procedures, medications and /or anesthetics to be administered by the attending dentist or his/her supervised staff for diagnostic purposes or dental treatment. I understand that no dental treatment is risk free and that my dentist will take reasonable steps to limit complications. I have had the opportunity to ask questions about risks and alternative treatments and understand my treatment plan.
Risks of treatment include but not limited to

_____

Signature/Guardian _____ Date _____