**Informed Consent for Dental Treatment**

1. I hereby authorize Shelby Pines Family Dentistry to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of your dental needs.

2. Upon such diagnosis, I authorize Shelby Pines Family Dentistry to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I hereby authorize Shelby Pines Family Dentistry to administer anesthetic, sedative and or nitrous oxide (laughing gas) as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications associated with this.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf. I understand that payment is due at the time of service unless other payment arrangements have been made. In the event that payment is not made I understand there may be a late charge added to my account. I also agree to pay for all collection costs if additional collection is required.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentists advice and recommendations regarding medication, pre and post treatment instruction, referrals to other dentists or specialist, and return for scheduled appointment. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

The patient is a very important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be assessed by your dentist.

**In accordance with the Health Insurance Portability and Accountability Act (HIPAA), this information will tell you about the ways in which we may use and disclose medical/dental information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your personal, identifiable health and medical information.**

****Please feel free to review the "PRIVACY POLICIES" booklet our office follows. The booklet will be located in the reception area next to the check in desk.**

Signature of Patient, Patient Representative of Parent of Patients under age 18

*By typing your name in the signature box above, you are certifying that the information included in this form is true to the best of your knowledge. Typing your full name in the signature above is the legal equivalent of your written signature, and will stand as such in all legal matters.

*If patient representative signs above, please describe the relationship to the patient:

**After filling out form, please save as to your desk top. Then attach the Consent Form from your desktop and send back.**

# DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____

Date of most recent dental exam_____/_____/_____ Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mom. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

| PLEASE ANSWER YES OR NO TO THE FOLLOWING: | YES | NO |
|---|---|---|
| **PERSONAL HISTORY** | | |
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very)_____ | ☐ | ☐ |
| 2. Have you had an unfavorable dental experience?_____ | ☐ | ☐ |
| 3. Have you ever had complications from past dental treatment?_____ | ☐ | ☐ |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic?_____ | ☐ | ☐ |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____ | ☐ | ☐ |
| 6. Have you had any teeth removed?_____ | ☐ | ☐ |
| **SMILE CHARACTERISTICS** | | |
| 7. Is there anything about the appearance of your teeth that you would like to change?_____ | ☐ | ☐ |
| 8. Have you ever whitened (bleached) your teeth?_____ | ☐ | ☐ |
| 9. Are you self conscious about your teeth?_____ | ☐ | ☐ |
| 10. Have you been disappointed with the appearance of previous dental work?_____ | ☐ | ☐ |
| **BITE AND JAW JOINT** | | |
| 11. Do you have any problems chewing certain foods?_____ | ☐ | ☐ |
| 12. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____ | ☐ | ☐ |
| 13. Are your teeth crowding or developing spaces?_____ | ☐ | ☐ |
| 14. Do you feel like you clench or grind your teeth?_____ | ☐ | ☐ |
| 15. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ | ☐ | ☐ |
| 16. Do you have tension headaches or sore teeth?_____ | ☐ | ☐ |
| 17. Do you wear or have you ever worn a bite guard?_____ | ☐ | ☐ |
| **TOOTH STRUCTURE** | | |
| 18. Have you had any cavities within the past 3 years?_____ | ☐ | ☐ |
| 19. Do you have a dry mouth?_____ | ☐ | ☐ |
| 20. Are any teeth sensitive to hot, cold, biting or sweets?_____ | ☐ | ☐ |
| 21. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?_____ | ☐ | ☐ |
| **GUM AND BONE** | | |
| 22. Have you ever been diagnosed or treated for periodontal (gum) disease?_____ | ☐ | ☐ |
| 23. Have you ever experienced gum recession_____ | ☐ | ☐ |
| 24. Is there anyone with a history of periodontal disease in your family?_____ | ☐ | ☐ |
| 25. Do your gums bleed when brushing, flossing or eating?_____ | ☐ | ☐ |
| 26. Are your teeth becoming loose?_____ | ☐ | ☐ |
| 27. have you ever noticed an unpleasant taste or odor in your mouth?_____ | ☐ | ☐ |
| 28. Would you like to keep all your teeth for life?_____ | ☐ | ☐ |

Signature of Patient, Patient Representative of Parent of Patients under age 18

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Shelby Pines Cosmetic & Family Dentistry

# MEDICAL HISTORY

PATIENT NAME_____ Birth Date _____Today's Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operations? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
Are you on a special diet Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

**Women: Are you**

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

**Are you allergic to any of the following?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

**Do you have, or have you had, any of the following?**

| | | | |
|---|---|---|---|
| AIDS/HIV Postive Yes No | Cortisone Medicine Yes No | Hemophilia Yes No | Radiation Treatments Yes No |
| Alzheimer's Disease Yes No | Diabetes Yes No | Hepatitis A Yes No | Recent Weight Loss Yes No |
| Anaphylaxis Yes No | Drug Addiction Yes No | Hepatitis B or C Yes No | Renal Dialysis Yes No |
| Anemia Yes No | Easily Winded Yes No | Herpes Yes No | Rheumatic Fever Yes No |
| Angina Yes No | Emphysema Yes No | High Blood Pressure Yes No | Rheumatism Yes No |
| Arthritis/Gout Yes No | Epilepsy or Seizures Yes No | High Cholesterol Yes No | Scarlet Fever Yes No |
| Artificial Heart Valve Yes No | Excessive Bleeding Yes No | Hives or Rash Yes No | Shingles Yes No |
| Artificial Joint Yes No | Excessive Thirst Yes No | Hypoglycemia Yes No | Sickle Cell Disease Yes No |
| Asthma Yes No | Fainting Spells/Dizziness Yes No | Irregular Heartbeat Yes No | Sinus Trouble Yes No |
| Blood Disease Yes No | Frequent Cough Yes No | Kidneys Problems Yes No | Spina Bifida Yes No |
| Blood Transfusion Yes No | Frequent Diarrhea Yes No | Leukemia Yes No | Stomach/Intestinal Disease Yes No |
| Breathing Problem Yes No | Frequent Headaches Yes No | Liver Disease Yes No | Stroke Yes No |
| Bruise Easily Yes No | Genital Herpes Yes No | Low Blood Pressure Yes No | Swelling of Limbs Yes No |
| Cancer Yes No | Glaucoma Yes No | Lung Disease Yes No | Thyroid Disease Yes No |
| Chemotherapy Yes No | Hay Fever Yes No | Mitral Valve Prolapse Yes No | Tonsillitis Yes No |
| Chest Pains Yes No | Heart Attack/Failure Yes No | Osteoporosis Yes No | Tuberculosis Yes No |
| Cold Sores/Fever Blisters Yes No | Heart Murmur Yes No | Pain in Jaw Joints Yes No | Tumors or Growths Yes No |
| Congenital Heart Disorder Yes No | Heart Pacemaker Yes No | Parathyroid Disease Yes No | Ulcers Yes No |
| Convulsions Yes No | Heart Trouble/Disease Yes No | Psychiatric Care Yes No | Venereal Disease Yes No |
| | | | Yellow Jaundice Yes No |

Have you ever had any serious illness not listed above? Yes No

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Shelby Pines Cosmetic & Family Dentistry

# PATIENT REGISTRATION

ID:_____ Chart ID:_____

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: _____

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: _____

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

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.:_____

### Section 3

Emergency Contact: _____

Contact Number: _____

## Primary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

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: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

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

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