Victorian Dental

GENERAL, COSMETIC AND IMPLANT DENTISTRY

We strive to incorporate new technology with excellence in patient care.

Please take a few minutes to answer questions that will help us better serve you.

First Name:_____ MI:_____Last:_____Preferred Name:_____
Home Phone:_____Work Phone:_____Cell:_____
Date of Birth:_____Male Female SS#:_____
Address:_____City:_____
State:_____ Zip Code:_____Marital Status: Married Single Widowed Divorced
Employer:_____
State/Driver's License #:_____Email:_____
Name of Primary Physician:_____Phone:_____
Emergency Contact:_____Relationship:_____Phone:_____
Date of Last Dental Exam/Cleaning:_____Were X-rays Taken?_____Yes _____No
How would you like us to confirm your appointments? O Phone Call O Text O Email

What is your primary concern regarding your teeth?

_____
_____
_____

Are you experiencing any pain or discomfort, and if yes please describe?

_____
_____
_____

How did you find Victorian Dental?

_____
_____

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his staff responsible for any errors that I have made in the completion of this form. *Adult/Guardian*: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be necessary by the Doctor.

Patient:_____Date: _____

Parent/Guardian (if patient is a minor):_____Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth 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 operation? ◯ 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 Positive ◯ 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	Kidney 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 _____

HEALTH INFORMATION PRIVACY POLICIES AND PROCEDURES

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider. We implement these policies and procedures as a matter of sound business practice, to protect the interests of our patients, and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), its implementing regulations at 45 CFR Parts 160 and 164 (65 Fed. Reg. 82462 [Dec 28, 2000] ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug 14, 2002]), and state law that provides greater protection or rights to patients than the privacy rules.

These Policies & Procedures address the basics of HIPPA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies and Procedures sometimes refer to forms we use to help implement the policies and to the privacy rules themselves when added detail may be needed. Please note that while the Privacy Rules speak in terms of 'individual' rights and actions, these Policies and Procedures use more familiar word 'patient' instead; 'patient' should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other 'individuals' contemplated in the Privacy Rules.

If you have questions or doubt about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies & Procedures, the Privacy Rules, or other federal or state law, consult us before you act.

_____

Printed Name Signature Date

CONSENT FOR TREATMENT & APPOINTMENT POLICY

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication 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.
4. I give consent to the doctor's designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I agree to pay all associated fees on delinquent balances should the office use an outside source for collections.

Appointment & Cancellation Policy:

Our staff is committed to providing the highest quality of dental care for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability, and material preparation. We reserve specific time in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and honor their appointments. We will attempt to contact our patients prior to their appointment to remind them of the date and time, but please do not depend on this courtesy.

Please be advised of the following requirements:

- We require **48 hours notice** for cancellation of a scheduled appointment.
- A cancellation fee of **$50.00** will be added for all missed or cancelled appointments with less than 24 hours notice. Appointments longer than 60 minutes will result in a higher fee.
- If there are three missed or cancelled appointments without 24 hours notice appointments in a year time frame, we reserve the right to not schedule any further appointments or require a deposit in order to schedule future appointments.
- Family/Medical emergencies will be taken into consideration.

By signing below, I have read and understand this consent and appointment policy for Victorian Dental. I have been given the opportunity to ask questions, and can request a copy of this policy at any time.

_____

Printed Name Signature Date