



Patient Information

First Name: _____ Last Name: _____ Middle Initial _____

Birth Date: Month _____ Day _____ Year _____ Email: _____

Address: _____

City/State/Zip: _____

Home Phone#: _____ Cell Phone#: _____

Work Phone#: _____

Emergency Contact Name: _____ Phone#: _____

Previous Dentist Name: _____ Phone#: _____

How did you hear about us?: _____

Responsible Party-Parent/Guardian

First Name: _____ Last Name: _____ Middle Initial _____

Birth Date: Month _____ Day _____ Year _____

Address: _____

City/State/Zip: _____

Primary Phone#: _____

Primary Insurance

Name of Insured: _____

Birth Date: _____

Insurance Company: _____

Insurance Phone#: _____

Policy ID or SSN: _____

Employer Name: _____

Secondary Insurance:

Name of Insured: _____

Birth Date: _____

Insurance Company: _____

Insurance Phone#: _____

Policy ID or SSN: _____

Employer Name: _____

Are you happy with your smile? _____ Would you like whiter teeth? _____

Are there any changes you would like to make to your smile? _____

CANCELLATION POLICY

At Truly Yours Family Dental, we understand your time is important and in result, we have reserved time for your visit with us. In the event you need to make changes to the appointed time, we request at least 48 business hours (2 business days) notice. To maintain quality of care and keep from overbooking, our office requires such notice, otherwise a **\$75 NO SHOW FEE** will apply. We understand that emergencies and illness may arise last minute, but please do give us enough time so that we may allow other patients to use that reserved time.

By signing below, you acknowledge you have listed all pertinent information, read and understand our Cancellation Policy and have had opportunity to review or receive a copy of our Privacy Practices.

_____ Date: _____

Patient/Responsible Party Signature

Although dental personnel primarily treat the are 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. Please answer the questions to the best of your knowledge.

- Are you currently under a physician's care? Yes No If Yes, _____
- Have you ever been hospitalized or had a major operation? Yes No If Yes, _____
- Have you ever had a serious head or neck injury? Yes No If Yes, _____
- Are you taking any medication, pills, or drugs? Yes No If Yes, _____
- Have you ever taken Fosamax, Boniva, Actonel or
Any other medication containing bisphosphonates? Yes No If Yes, _____
- Are you on a special diet? Yes No If Yes, _____
- Do you use tobacco? Yes No If Yes, _____
- Do you use controlled substances? Yes No If Yes, _____

Women: Are you....

- Pregnant/ Trying to get pregnant? Nursing? Take oral contraceptives?

Are you allergic to any of the following?

- Acrylic Aspirin Codeine Latex Local Anesthetic Metal Penicillin
- Sulfa Drugs Other _____

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

- | | | | | | |
|-------------------------------|--|-------------------------------|--|--------------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/
Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/
Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/
Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/
Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/
Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart
Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsilitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
- Have you ever had any serious illness not listed above? If yes, _____

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.

Print Patient Name _____ Signature of Patient/Guardian _____ Date: _____

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Initial lines 1 thru 5, and the remaining as needed.

EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan. (Initials _____)

DRUGS AND MEDICATION

I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

(Initials _____)

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials _____)

DENTAL PROPHYLAXIS

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease. (Initials _____)

PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc). Alternative treatment plans have been explained to me, including non-surgical therapy, antimicrobial treatment, gum surgery and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work. (Initials _____)

FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of newly placed fillings. (Initials _____)

CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are cemented. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit size and color) will be before cementation. It has been explained to me that in few cases, routine and cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of

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daily cleaning procedures. If a restoration other than a "same day crown or bridge" it is my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. (Initials _____)

BRIDGE OR IMPLANT PLACEMENT

I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant crown may not be a covered benefit under an insurance policy. (Initials _____)

DENTURES-COMplete OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliance have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changed in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. (Initials _____)

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost despite all efforts to save it. (Initials _____)

NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant. (Initials _____)

DENTAL BENEFITS

It is very important that you read your insurance policy. Our office bills insurance as a courtesy and makes no guarantees of coverage. We do not allow insurance to influence our treatment plans. We will assist you in maximizing your benefits; however our treatment plans are based on dental necessity. Some common non covered procedures, but not limited to are tooth colored fillings on back teeth (we no longer place amalgam fillings due to the high content of mercury), fluoride varnish, sealants over the age of 14, specific unique procedures requiring additional laboratory costs. Examples are same day EMAX or same day crowns, splints, all porcelain crowns, Valplast partial dentures, implant procedures, occlusal (night) guards.

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit the dental office will apply any insurance benefit to the treatment plan and I am responsible for any unpaid amount by the insurance carrier. (Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized.

Signature _____ Date _____

Doctor _____ Date _____