embrace DENTISTRY

PATIENT MEDICAL FORM

PATIENT'S FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

❑ Male ❑ Female Date of Birth ____/____/____ Soc. Sec. No. _____ ❑ Single ❑ Married

Address _____ City/State/Zip _____

Cell Phone: _____ Secondary Phone: _____ Email: _____

What is your preferred method of communication for scheduling appointments? ❑ Text Message ❑ Personal Phone Call ❑ Email ❑ All

Emergency Contact: _____ Phone: _____ Parent's Name (if a minor): _____

How did you hear about Embrace Dentistry:

❑ **Radio** ❑ **Mail** ❑ **Our Website** ❑ **Facebook** ❑ **TV** ❑ **Embrace Sign** ❑ **Google** ❑ **Friend** _____

What is your level of dental anxiety? 1-No Fear / Anxiety to 10-Extremely Anxious or Fearful

1 2 3 4 5 6 7 8 9 10

Do you have any immediate dental concerns? _____

Is there anything that bothers you about your smile? _____

Have you had a bad experience at a dental office? _____

Is there anything that bothers you about dentistry? _____

Would you prefer sedation to sleep through your dental procedures? ❑ Yes ❑ No ❑ Would like to learn more

Dental Insurance Company: _____

Group ID: _____ Subscriber/Member ID: _____

Name of Insured: _____ Employer: _____

Relationship to insured: _____

Social Security #: _____ Birthdate: _____

Do you have secondary dental insurance? ❑ Yes ❑ No

DENTAL HISTORY:

Do your gums bleed when brushing or flossing? ❑ Yes ❑ No

Do you feel pain with any of your teeth? ❑ Yes ❑ No

Do you feel any pain or clicking in your jaw? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

Have you ever been treated for periodontal disease? ❑ Yes ❑ No

Are you currently under the care of another dentist? ❑ Yes ❑ No

When was your last dental exam or cleaning? _____

CONSENT FOR SERVICES:

Please be advised that this office primarily uses white filling materials in the front and back teeth. Be advised that white filling material is a better material in most clinical situations, however the majority of insurance companies will pay a lower percentage for white fillings.

This practice depends on reimbursement from the patient for the costs incurred in their care. **Payment is expected when services are rendered**. **Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.** This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Estimated patient cost must be paid at the time of service. If your account has not been paid by insurance within 30 days, it is your responsibility to contact the insurance company.**

I grant permission to you or your assignee to telephone me at home or at work to discuss matters related to this form or my account. I also grant permission for your office to speak with other professions concerning my dental care. Embrace Dentistry has presented me a copy of the *Notice of Privacy Practices.* This notice provides in detail the uses and disclosures of my protected health information, my individual rights, and how I may exercise these rights. This practice is HIPPA compliant and has policies available if you would like to review them. I have read the above statements and conditions of treatment and payment and agree to their content. To the best of my knowledge all the information I have provided is accurate and true.

_____ _____

Signature of Patient or Responsible Party Date

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO		YES	NO
Artificial Joints	☐	☐	HIV	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Biosphosphonates	☐	☐	Liver Disease	☐	☐
Blood Thinners	☐	☐	Mental Disorders	☐	☐
Cancer	☐	☐	Pacemaker	☐	☐
Codeine Allergy	☐	☐	Penicillin Allergy	☐	☐
Diabetes	☐	☐	Currently Pregnant	☐	☐
Dizziness	☐	☐	Respiratory Problems	☐	☐
Emphysema	☐	☐	Sinus Problems	☐	☐
Epilepsy	☐	☐	Sleeping Problems	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
Head Injury	☐	☐	Thyroid Medicine	☐	☐
Heart Disease	☐	☐	Tobacco Use	☐	☐
Heart Murmur	☐	☐	Tuberculosis	☐	☐
Heart Trouble	☐	☐	Tumors	☐	☐
Hepatitis	☐	☐	Ulcers	☐	☐
High Blood Pressure	☐	☐	Other	☐	☐

PLEASE LIST YOUR ALLERGIES: _____

_____

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

SLEEPING HISTORY:

1. Do you snore? ☐ Yes ☐ No
2. Has anyone ever said you stopped breathing in your sleep? ☐ Yes ☐ No
3. Do you have headaches especially in the morning? ☐ Yes ☐ No
4. Do your jaws pop and click? ☐ Yes ☐ No
5. Do you have a deviated septum? ☐ Yes ☐ No
6. Do you wake up feeling refreshed in the morning? ☐ Yes ☐ No
7. Have you ever had a sleep test? ☐ Yes ☐ No
8. Does anyone in your family have sleep apnea? ☐ Yes ☐ No

By signing and dating below, you agree that the information on the front & back of this form is up to date and accurate.

Signature of Patient or Responsible Party _____ Date _____

Signature of Doctor _____ Date _____

OFFICE USE ONLY:

By initialing and dating below, you agree that the information on the front & back of this form is up to date and accurate.

Initials	Date	Initials	Date	Initials	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____