WELCOME TO DELTA OAKS DENTAL CARE

PATIENT INFORMATION:

Name: ____

Age: ________ Date of Birth: ____________ Soc. Sec. Number: __________________________

Address: ______________________________ City/State: ______________ Zip: ________

Phone #'s: Home: __________________ Work : _________________ Cell : __________________

RESPONSIBLE PARTY: ☐ **Self** ☐ **Other (If younger than 18 yrs. – please fill out below)**

Name:______________________________ Date of Birth: __________ SS#: ________________

Address:________________________________ City/State: ______________ Zip: ________

Phone #'s: Home: __________________ Work : _________________ Cell : __________________

Occupation: _________________ Employers Name: ____________________________________

PRIMARY INSURANCE INFORMATION:

Subscriber: ☐ **Self** ☐ **Other (Fill out below)**

Name: ______________________________ Date of Birth: ________ Relation to Patient: __________

Ins. Company: _____________________ Group #: ____________ Phone #: _________________

Address: ______________________________ City/State: ______________ Zip: ________

Employer: ___________________________ Soc. Sec. # / ID#: ___________________________

SECONDARY INSURANCE INFORMATION:

Name: ______________________________ Date of Birth: ________ Relation to Patient: __________

Ins. Company: _____________________ Group #: ____________ Phone #: _________________

Address: ______________________________ City/State: ______________ Zip: ________

Employer: ______________________________ Soc. Sec. # / ID#: ________________________

Your Spouse:

Name: ______________________ Employer: __________________ Work Phone #: ____________

Is another member of your family or relative a patient at our office:

Name: ____________________________________ Relationship: ___________________

You were referred to us by: ____

Emergency Contact: ________________________________ **Phone#:** _______________

New Patient Consent for Treatment:

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2) Upon such diagnosis, I authorize 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 complications.
4) I give consent to the doctor's or 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 healthcare operations. I understand that only 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.

Financial Agreement:

Financial Agreement:

- I agree to be responsible for payment of all services rendered on my behalf or my dependants. **I understand that payment is due at the time of service unless other arrangements have been made.** I also understand that I may be responsible for the payment of services rendered if the services are not covered by my insurance. Insurance will be billed according to the billing/payment guideline of my primary insurance **as a courtesy** to patients. Charges will be my responsibility if I fail to provide accurate insurance information to the business office within 30 days of the date of service. In the event that payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.

Payment Agreement:

- Deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to incorrect insurance eligibility are my responsibility.
- Accounts are to be paid prior to service date, unless financial arrangements have been made. Payment will be required regardless if claims are denied, unsettled or unpaid by the insurance company.
- I understand that delinquent accounts will be assigned to a credit reporting collection agency and I will be charged a $100 collection fee.

Assignment of Insurance Benefits:

- I authorize my insurance company(s) to pay Dr. Firas Salhi & Dr. Terry Lynn Tennant all insurance benefits for dental services rendered to me or members of my family.

Additional Charges:

- If you are unable to keep a scheduled appointment, we ask that you give our office 2 business days notice. Without this notice, a charge will be assessed for time reserved, and future appointments will need to be pre-paid. Our office hours are Monday-Thursday, 7 am – 5 pm.

Release of Information:

- I hereby authorize Delta Oaks Dental Care to furnish information needed to the insurance company, other payor or their representatives, and all information required to process my claim. I also authorized Delta Oaks Dental Care to release information that may be needed for my treatment only to other healthcare professionals

HIPAA:

Acknowledgement of receipt of notice of privacy practices:

- I was offered or have received a copy of this office's “Notice of Privacy Practices”.

__________________________________ _______________

Patient/Guardian Signature **Date**

DENTAL HISTORY …

WELCOME! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential

Patient Name: ____ **Date:** _____________

What is the reason for your visit today? ____

Date of Last Dental Visit _________**Last Dental Cleaning**_________**Last Full Mouth X-rays** ________
What was done at your last visit? ____

Previous Dentist name: ____________________________ **Telephone** __________________________

How often do you have dental examinations? ____
How often do you brush your teeth? ________ **How often do you floss?** ________________________
What other dental aids do you use? (Interplak, toothpick, etc) _______________________________

Do you have any dental problems now? ❑ Yes ❑ No
If yes, please describe: ____

Are any of your teeth sensitive to:		**Have you ever had:**	
Hot or Cold	❑ Yes ❑ No	Orthodontic treatment	❑ Yes ❑ No
Sweets	❑ Yes ❑ No	Oral Surgery	❑ Yes ❑ No
Biting or chewing	❑ Yes ❑ No	Periodontal treatment	❑ Yes ❑ No
Have you noticed any mouth odors or bad tastes?	❑ Yes ❑ No	Your teeth ground or the bite adjusted	❑ Yes ❑ No
Do you frequently get cold sores, blister or any other oral lesions	❑ Yes ❑ No	A bite plate or mouth guard	❑ Yes ❑ No
	❑ Yes ❑ No	A serious injury to the mouth or head	❑ Yes ❑ No
		If so, please describe, including cause ______________________	
Do your gums bleed or hurt?	❑ Yes ❑ No	**Have you experienced**:	
Have your parents experienced gum disease or tooth loss	❑ Yes ❑ No	Clicking or popping of the jaw	
Have you noticed any loose teeth or change in your bite	❑ Yes ❑ No	Pain? (joint, ear, side of face)	
Does food tend to become caught in between your teeth	❑ Yes ❑ No	Difficulty in opening or closing the mouth	❑ Yes ❑ No
If yes, where? ________________		Difficulty in chewing on either side of the mouth	
		Headaches, neckaches or shoulder aches	❑ Yes ❑ No
		Sore muscles (neck, shoulders)	❑ Yes ❑ No
Do you:		Are you satisfied with your teeth's appearance?	❑ Yes ❑ No
Clench or grind your teeth while awake or asleep	❑ Yes ❑ No	Would you like to keep all of your teeth all of your life	❑ Yes ❑ No
Bite your lips or cheeks regularly	❑ Yes ❑ No	Do you feel nervous about having dental treatment	❑ Yes ❑ No
Hold foreign objects with your teeth (Pencils, pipe, pins, nails,fingernails)	❑ Yes ❑ No	If so, what is your biggest concern? ______________________	❑ Yes ❑ No
Mouth breathe while awake or asleep	❑ Yes ❑ No	Have you ever had an upsetting dental experience?	
Have tired jaws, especially in the morning	❑ Yes ❑ No	If yes, please describe ______________________	❑ Yes ❑ No
Snore or have any other sleeping disorders	❑ Yes ❑ No		❑ Yes ❑ No
Smoke/chew tobacco or use other tobacco products	❑ Yes ❑ No		

Is there anything else about having dental treatment that you would like us to know? ❑ Yes ❑ No
If yes, please describe ____
____
____

MEDICAL HISTORY

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 medications 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?	O **Yes** O **No**	If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation?	O **Yes** O **No**	If yes, please explain: ______________________
Have you ever had a serious head or neck injury?	O **Yes** O **No**	If yes, please explain: ______________________
Are you taking any medications, pills, or drugs?	O **Yes** O **No**	If yes, please explain: ______________________
Do you take or have you taken, Phen-Fen or Redux?	O **Yes** O **No**	If yes, please explain: ______________________
Are you on a special diet?	O **Yes** O **No**	If yes, please explain: ______________________
Do you use tobacco?	O **Yes** O **No**	If yes, please explain: ______________________
Do you use controlled substances?	O **Yes** O **No**	If yes, please explain: ______________________

Women: Are you
Pregnant/Trying to get pregnant? O **Yes** O **No** Taking Oral Contraceptives? O **Yes** O **No** Nursing? O **Yes** O **No**

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____

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

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

Have you ever had any serious illness not listed above? O **Yes** O **No** If yes, please explain: ______________________

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 ______________