ANNIGAN Dental

Name | Nickname | DOB

Address/City/State/Zip

SSN | Mobile Phone | Home Phone

E-Mail | Gender

Driver's License # | Referred By

Employment Status

Do you currently have dental insurance? | Insurance Company

Policy Holder if NOT Patient | DOB | Relationship

Member ID | Employer

Appointment Preference

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ On short notice
- ☐ No preference

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

Are you under a physician's care now? if yes:	Yes	No
Have you ever been hospitalized/had a major operation? if yes:	Yes	No
Have you ever had a serious head/neck injury? if yes:	Yes	No
Are you taking any medications/pills/drugs? if yes:	Yes	No
Do you have/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

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Do you use tobacco? Yes No
if yes, what type(s):

Women: Are you

- ☐ Pregnant
- ☐ Trying to get pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa drugs

Other:

Do you have/had you had any of the following?

- ☐ AIDS/HIV positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/gout
- ☐ Artificial joint
- ☐ Asthma
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Breathing problems
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Cold sores/fever blisters
- ☐ Congenital heart disorder
- ☐ Convulsions
- ☐ Cortisone medicine
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Excessive thirst
- ☐ Fainting spells/dizziness
- ☐ Frequent cough
- ☐ Frequent diarrhea
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart attack/failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart trouble/disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hives or rash
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Kidney problems
- ☐ Leukemia
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve problems
- ☐ Osteoporosis
- ☐ Pain in jaw joints
- ☐ Parathyroid disease
- ☐ Psychiatric care
- ☐ Radiation treatments
- ☐ Recent weight loss
- ☐ Renal dialysis
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Spina bifida
- ☐ Stomach/intestinal disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Yellow jaundice

Have you ever had a serious illness not listed above? Yes No
if yes:

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Dental History:

Reason(s) for today's visit?

- ☐ Check-up
- ☐ Cleaning
- ☐ Pain
- ☐ Other

If other, please explain:

How long since your last visit to the dentist?

- ☐ 1-3 months
- ☐ 6-12 months
- ☐ 1 year or more
- ☐ I've never seen a dentist

Who is your previous dentist?

May we request records? Yes No
(if yes, please let front staff know so we can provide you with the proper paperwork)

Have you ever had any serious concerns or complications following dental treatment? Yes No
if yes, please explain:

Have you ever had any unfavorable reactions to dental anesthesia or sedation? Yes No
if yes, please explain:

Does dental treatment make you nervous Yes No

Are your teeth sensitive to hot, cold, biting, sweets or brushing any part of your mouth? Yes No

Have you had any cavities in the last 3 years? Yes No

Have you ever broken teeth, chipped teeth, had a toothache or cracked a filling? Yes No

How often do you brush?

- ☐ Never/occasionally
- ☐ Once a day
- ☐ Twice a day
- ☐ More than twice

How often do you floss?

- ☐ Never/occasionally
- ☐ Once a day
- ☐ Twice a day
- ☐ More than once

Do you have any problems chewing? Yes No

Have your teeth changed in the last 7 years? Check all that apply

- ☐ Crowding or developing spaces
- ☐ Become short, thinner or worn

Do you have any problems with the following? Check all that apply

- ☐ Sleepiness
- ☐ Tension headaches
- ☐ Sore teeth
- ☐ Problems with your jaw joints (pain, locking, limited opening, popping/sounds, etc.)

Have you ever worn a bite appliance (ex. night guard)? Yes No

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Sleep Apnea

Have you been diagnosed with sleep apnea or have you participated in a sleep study?	Yes	No
Have you had restless sleep, wake up feeling unrested or feel tired during the day?	Yes	No
Do you snore or have you been told you stop breathing in your sleep?	Yes	No
Do you have any family member with a history of obstructive sleep apnea?	Yes	No

Oral Cancer Risk

Do you drink more than 8 (female) or 14 (male) alcoholic beverages in a week?	Yes	No
Have you or any members of your family been diagnosed with cancer or tumors of any type? if yes, who/what type?	Yes	No

Have you ever been vaccinated for the Human Papilloma Virus (HPV)?	Yes	No	Unsure

Gum Disease

Do you experience frequent bad breath?	Yes		No
Do your gums bleed when your brush or floss?	Yes		No
Have you or any member of your family been diagnosed with gum disease (periodontitis/gingivitis)?	Yes	No	Unsure

Smile

Do you like your smile?	Yes	No

I am interested in: check all that apply

- ☐ Breath control
- ☐ Closing spaces
- ☐ Cosmetic evaluation
- ☐ Home care
- ☐ Replacing missing teeth
- ☐ Restoring worn/broken teeth
- ☐ Sedation
- ☐ Straight teeth
- ☐ Teeth whitening
- ☐ White fillings

ANNIGAN
Dental

Office Policy

Thank you for choosing Annigan Dental as your family dental provider. We look forward to providing you high quality dental care at an affordable price.

When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you find a need to reschedule your appointment, we ask for a minimum of 24 hours' notice. Cancellations must be done by speaking directly to one of our dental staff members during normal business hours. Patients whose appointments are continuously changed or cancelled without 24 hours' notice will be subject to discontinuation from our practice.

Checks returned for insufficient funds are subject to a $35.00 fee. This fee is enforced to cover our bank charges. Please let us know if special arrangements must be made.

Patient portion is due at time of service. Please bring your co-payment with you. All financial arrangements must be made prior to your appointment date. We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion for services is based upon the information provided by your insurance company and is expected on the day treatment is rendered. Please ask for an estimate if one has not already been given to you. We ask that you notify us of any changes to your insurance or contact information as soon as possible to avoid problem claims and unexpected balances.

I declare that I am not a recipient of state assisted insurance, including but not limited to DSHS.

Patient acknowledges in consideration for dental services to be rendered any outstanding debt to our office will not be included in any bankruptcy petition.

Thank you again for understanding and care with helping to keep our facilities safe and clean. Thank you for helping us provide you with the best possible dental care.

Patient's Name (Print) *Signature of Patient*

Relationship to Patient *Date*

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HIPAA – Acknowledgement of Receipt of Statement of Privacy Practice

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Annigan Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Annigan Dental reserves the right to change the Privacy Practices currently described in the Statement of Privacy Practices. If Privacy Practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Additional Disclosure Authorization

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specially authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only Yes No

OR

Any member of my immediate family (spouse, children, children's spouses) Yes No

If yes, who?

Any member of my extended family (parents, grandchildren) Yes No

If yes, who?

Other Yes No

If yes, who?

Patient's Name (Print) *Signature of Patient*

Relationship to Patient *Date*

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement obtained? Yes No

If no, why?

Provided prior to treatment? Yes No

Date