32 DENTAL ARTS

Dental History

Patient Name: _____
Date of Birth: _____
Date of Last Dental Visit ____/____/_____ Reason for the Visit? _____
Date of Last Dental X-rays? _____/_____/_____
Former Dentist:_____Phone: _____
Address:_____City:_____State:_____Zip:_____
If you left your previous dentist, what was the reason? _____
What is important to you in a dentist or dental practice? _____

At-Home Oral Hygiene Care

How often do you brush your teeth? _____
How often do you floss? _____
Do you use any other dental home care products? Yes/No
If YES, which kind: _____

Circle Appropriate Answer (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No
   If YES, explain: _____
2. Do your gums bleed? Yes/No
   If YES, explain: _____
3. Are your teeth loose? Yes/No
   If YES, explain: _____
4. Do you wear dentures or partials? Yes/No
   If YES, explain: _____
5. Have you ever been told you have gum disease? Yes/No
   If YES, explain: _____
   Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No
   If YES, explain: _____
6. Have you ever had any clicking, popping or discomfort in the jaw? Yes/No
   If YES, explain: _____
7. Do you clench or grind your teeth? Yes/No
8. Do you wear a Night-guard or Athletic mouth-guard? Yes/No
9. Have you ever had orthodontic treatment (braces) before? Yes/No
10. Do you have dry mouth? Yes/No
11. Does food or floss catch between your teeth? Yes/No
12. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No
    If YES, explain: _____

13. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
    If YES, explain: _____

14. Have you ever been pre-medicated for dental treatment? Yes/No
    If YES, explain: _____

15. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
    If YES, explain: _____

16. Are you happy with your smile? Yes/No
    If NO, please explain: _____

17. What would you change about the present condition of your mouth? _____
    _____

18. Is there anything else you would like us to know about your dental health or dental history? Yes/No
    If YES, explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) **Date**

_____ _____

Signature of Dentist **Date**

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No	Local anesthetic
Yes / No Metal		

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal supplements	

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Patient Responsibilities

It is our top priority to provide you with the best possible care and help you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Reservation Policy

We consider your appointment confirmed when we reserve time in our schedule either verbally by phone or in person but offer courtesy reminders by email and text messaging. We take pride in preparing for your appointments and setting up our treatment rooms specifically for you. Therefore, we do ask that you help us maintain our service to you and to other patients by providing a 48 hour notice if you need to change your appointment.

We know life can bring about unexpected events and we do understand if you are unable to keep your appointment. However, due to our new scheduling protocols emphasizing safety measures, we are unable to accommodate same day changes to reserved appointment times due to broken or missed appointments. To help us maintain our standard of service, we do require a 48 hours' notice to reschedule an appointment. With less than 48 hours' notice, a fee of $ 50 will be incurred for broken or changed appointments. A deposit to reserve an appointment time may be required in the event more than one appointment was changed or broken. To serve all of our patients in a timely manner, we may need to reschedule an appointment or modify the planned treatment for that visit if a patient is 10 minutes late or more arriving to our practice. A deposit to reschedule an appointment due to late arrival may be required.

Payment

Our fees are based on the quality of materials we use and reflects the extensive training that our doctor and team have taken to improve patient care. Our fees fall within the usual and customary range for our area. We like to see all our patients achieve dental health and will do our best to assist you in understanding your payment options and insurance benefits. Payment is due at the time services are rendered. Financial arrangements and payment options are available and we can review them with you before you begin any treatment in our practice.

Dental Benefit Plans

Your dental benefit is a contract between you and your employer and the dental insurance carrier. We are happy to guide you in understanding your policy and your coverage plan but we do not determine your dental coverage and not every procedure we advise will be covered.
If we are a contracted provider with your plan, we are required to collect your portion in full at the time of service. It is your responsibility to notify us if your employment status changes or if your insurance policies are no longer active so that you can avoid an unexpected bill.

If we are not a contracted provider with your plan, you may still be treated at our office, though it will be your responsibility to verify that the plan allows you to receive reimbursement for services from out-of-network providers. We would still be able to file your claim for you if you “assign benefits” to us.

Ultimately, we are committed to your oral health and together, we can help you achieve your dental goals.

I have read the above and agree to the financial and scheduling terms.(initial) _____

I authorize the release of information necessary to process my dental benefits claims. I hereby authorize payment directly to this doctor otherwise payable to me.(initial)_____

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need, and have been given an explanation of the diagnosis and treatment advised to make an informed decision on my treatment. (initial) _____

_____ _____

Signature Date

Acknowledgment of Notice of Privacy Practices, Dental Materials Fact Sheet and Consent for Use and Disclosure of Health Information.

By signing below, I am authorizing 32 Dental Arts to use or disclose your protected health information to the entities listed below for the purpose of payment activities and treatment coordination. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be revoked or modified at any time in writing to this dental practice. I understand that I may refuse to sign this authorization and that my treatment will not be conditioned or affected in any way on signing. I understand I may have a copy of this authorization. I also acknowledge I am receiving the Dental Board of California's Material Sheet that describes different materials used to restore teeth.

Dr. Barakat is committed to professional advancement and participates in professional continuing educational associations where dentists share and present their patient cases amongst themselves. Unless I check the box below, I give her permission to use my dental and health information anonymously and only as they relate to my dental condition for education purposes only.

- ❑ Do not use my clinical information for educational purposes

Entities to receive information: *(Please indicate who is authorized to receive your dental and health information and their relationship to you)*_____

Description of health information to be used or disclosed is limited to :

_____Results of x-rays/diagnosis
_____General dental needs
_____Financial information
_____Other

_____ _____
Signature of Patient or Patient Representative Date

_____
Patient Name (Please Print)

_____
Description of Legal Representative's Authority