ANDLER DENTAL
FAMILY • COSMETIC • IMPLANTS

Patient Information

First Name:_____ Last Name:_____ Middle Initial:____

Address1: _____Address2:_____

City:_____ State/Zip:_____

Cell Phone:_____Home Phone:_____ Work Phone _____Ext:____

Sex: ◯ Male ◯ Female ◯ Other

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date:_____ Age:_____

E-Mail:_____ Preferred Pharmacy _____

How did you hear about us? (circle)

Another patient _____ Website Outdoor Sign Other _____

Responsible Party (if someone other than patient)

First Name:_____ Last Name:_____ Middle Initial:____

Birth Date:_____

Address – Same as above? - Circle → **YES (skip next two lines)**

Address 1:_____ Address 2:_____

City, State, Zip:_____

Phone numbers – Same as above? – Circle → **YES (skip next line)**

Home Phone:_____WorkPhone:_____Ext.____Cellular:_____

◯Responsible Party is also a Policy Holder for Patient ◯Primary Insurance Policy Holder
◯ Secondary Insurance Policy Holder

Dental Insurance Information (if applicable)

Place of Employment _____ Insurance Company _____

Group ID # _____ Member ID # _____

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Patient Name: _____ D.O.B.: _____

Emergency Contact (Name/Phone #): _____

Adult Medical History

1.Physician: _____ Address or Clinic (Dean/GHC/UW/Other): _____

2.When was your last physical examination? _____

3. Are you under the care of a physician?..... □Yes □No

If yes, for what reason(s)? _____

4.Are you presently taking any medications/drugs/pills/herbals/supplements? ..... □Yes □No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant? ..... □Yes □No

If yes, anticipated due date? _____

6. Do you take oral contraceptives? ..... □Yes □No

7. Are you allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex □Pine Nuts

□Dyes □Other: _____

8. Do you smoke, chew tobacco, cigars, or use E-cigarettes? ..... □Yes □No

If yes, please indicate which one(s), daily frequency, and how long? _____

9. Do you have Diabetes? ..... □Yes □No

If yes, please indicate: □Type 1 □Type 2 Last HbA1c date and level_____

10. Do you have, or have you ever had:

Abnormal blood pressure.....□Yes □No

Anemia .....□Yes □No

Arthritis .....□Yes □No

Artificial heart valve/stent/graft….□Yes □No

Artificial joint replacements ..... □Yes □No

Asthma ..... □Yes □No

Cancer .....□Yes □No

Chemotherapy/radiation .....□Yes □No

Congenital heart defects .....□Yes □No

Corticosteroid treatment .....□Yes □No

Drug dependency
(alcohol/prescription).....□Yes □No

Epilepsy/seizures .....□Yes □No

Excessive or prolonged bleeding .....□Yes □No

Fainting spells .....□Yes □No

Glaucoma .....□Yes □No

Hearing impaired .....□Yes □No

Heart murmur .....□Yes □No

Heart pacemaker .....□Yes □No

Heart surgery .....□Yes □No

Heart trouble .....□Yes □No

Hepatitis (Type __) .....□Yes □No

HIV positive/AIDS .....□Yes □No

Jaundice .....□Yes □No

Kidney trouble/Dialysis .....□Yes □No

Oral herpetic lesions .....□Yes □No

Osteoporosis/treatment w/ Bisphosphonates…….....□Yes □No

Psychiatric care .....□Yes □No

Rheumatic fever .....□Yes □No

Sexually transmitted disease .....□Yes □No

Sinus trouble .....□Yes □No

Stroke .....□Yes □No

Taking Warfarin…….□Yes □No

If yes, last INR # _____

Thyroid problem .....□Yes □No

Tuberculosis or Lung Disease .....□Yes □No

Ulcers/GERD .....□Yes □No

11. Do you take pre-medication for anything? ..... □Yes □No

If you pre-medicate, what for? _____

12. Have you had any other serious illness, hospitalization or accident? ..... □Yes □No

If yes, please explain: _____

Adult Dental History

1.Former Dentist_____Address_____

2. When did you last visit a dentist? _____ When was your last cleaning? _____

X-rays taken? ..... □Yes □No

If yes, □Full Mouth Series □Bitewings □Panoramic

What was done at your last visit? _____

Why did you leave that dentist? _____

Has any dental treatment been recommended to you that you have not had done? _____

3. Are you aware of any dental problems ..... □Yes □No
If yes, please explain: _____

4. Please rate the present condition of your mouth: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

5. Have you ever been treated for gum disease? ..... □Yes □No
If yes, what was done?

_____

6. Do you have well water? ..... □Yes □No

7. Is your water fluoridated? ..... □Yes □No

8. Are your teeth sensitive to: □Nothing □Sweet □Cold □Heat □Pressure

9. Please rate the appearance of your smile: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

10. Would you like a whiter smile? ..... □Yes □No

11. Would you like straighter teeth?.....□Yes □No

12. Have you had your teeth straightened/worn braces? ..... □Yes □No

13. Are you concerned with bad breath (malodor)? ..... □Yes □No

14. Are you concerned with snoring or sleep apnea? ..... □Yes □No

15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... □Yes □No

16. Do you wear a bite guard? ..... □Yes □No

17. Are you aware of possible TMJ problems? Does your jaw joint make noise, lock up, or create pain....□Yes □No

18. Is there anything else that would be valuable for your dentist to know to best care for you?

_____

_____

□ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

□ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.

□ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient/Guardian's Signature _____ Date _____

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Patient Name:_____ D.O.B._____

Parent/Guardian's Name:_____ Relationship to Child:_____

Emergency Contact (Name/Phone #): _____

Child Medical History

1.Does your child have any current health problems?:……...□Yes □No

If yes, please explain:_____

2. Is your child under care of a physician?: ……...□Yes □No

Name of physician: _____

3. Is your child receiving any prescriptions, herbal, or OTC medications?: ……..…□Yes □No

If yes, what and when? _____

4. Has your child had any serious illness?: ……....□Yes □No

If yes, what and when? _____

5. Has your child ever had surgery or is surgery contemplated?:…...…….....□Yes □No

If yes, explain: _____

6. Does your child experience severe or prolonged bleeding?:.....□Yes □No

7. Does your child have frequent headaches?:……....□Yes □No

8. Is your child allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic
□Latex □Pine Nuts □Dyes □Other:_____

9. Does your child have, or have your child ever had:

ADD/ADHD..... □Yes □No

AIDS/HIV……...□Yes □No

Asthma ..... □Yes □No

Autism..... □Yes □No

Behavioral problems ..... □Yes □No

Cancer ..... □Yes □No

Cerebral palsy .....□Yes □No

Developmental delay .....□Yes □No

Diabetes .....□Yes □No

Epilepsy/seizures/fainting .....□Yes □No

Eating disorders .....□Yes □No

Hay fever/seasonal allergies ..□Yes □No

Hearing impaired .....□Yes □No

Heart condition……...□Yes □No

Hepatitis/jaundice .....□Yes □No

Hospitalizations .....□Yes □No

If yes, for: _____

Kidney infection .....□Yes □No

Liver problems .....□Yes □No

Oral herpetic lesions.....□Yes □No

School problems .....□Yes □No

Speech impairments .....□Yes □No

Thyroid problems .....□Yes □No

Rheumatic fever .....□Yes □No

Child Dental History

1.This is my child's first visit to the dentist:…… □Yes □No

2. When does you child brush his/her/their

□Upon arising □After any food □Right after meals □Before bedtime

3. Do you currently receive Fluoride in their drinking water?: ……□Yes □No

4. Does your child receive supplemental Fluoride at home?: ……□Yes □No

5. Do you monitor your child's sugar intake in food, snacks, and drinks……..□Yes □No

6. Have any cavities been noted in the past?:……..…....□Yes □No

7. Does your child suck his/her/their thumb or fingers?:……□Yes □No

8. Were any teeth (baby or permanent) removed by extraction?: ……..□Yes □No

9. Has a space maintainer been recommended?:…….....□Yes □No

If so, has a space maintainer been placed?:……...□Yes □No

10. Has your child had any problem with dental treatment in the past?: ……..….□Yes □No

11. Has anyone in the family, including parents, had orthodontics?:…….□Yes □No

12. Has your child ever received a local anesthetic?: ……□Yes □No

13. Has your child ever had occlusal sealants?:……□Yes □No

If yes, when?:_____

14. Does your child think there is anything wrong with his/her/their teeth?: ……...□Yes □No

15. Have there been any injuries to teeth, such as falls, blows, chips, etc.?: …….....□Yes □No

16. Does your child grind, clench, or brux their teeth?: ……..…□Yes □No

17. Does your child snore?: ……..……..….□Yes □No

18. Is there anything else that would be valuable for your dental team to know to best care for your child?.....□Yes □No

Explain:_____

□ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

□ I authorize the release of any information concerning my child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.

□ I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's/Guardian's Signature _____ Date_____

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HIPAA- PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Name of Patient: _____

Printed Name of Patient

Signature: _____ **Date:** _____

Relationship to Patient (if other than patient): _____

Below, please let us know if there is anyone you would like to give permission to receive information about your appointments or chart:

Last Name: _____ First Name: _____

Last Name: _____ First Name: _____