PATIENT HEALTH HISTORY

Today's Date _____

Patient Name _____ Birthdate _____

DENTAL HISTORY

Reason for Today's Visit _____ Are you having dental pain now? _____

Former Dentist _____ Date of last dental visit _____ Last x-rays _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal Treatment
- ☐ Difficult extractions
- ☐ Sensitivity to hot
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Pain with biting
- ☐ Sores or growths in your mouth
- ☐ Canker sores or cold sores
- ☐ Dry mouth
- ☐ Head, neck or jaw injury

How often do you floss? _____ How often do you brush? _____

Do you like the color of your teeth? (Y/N) _____ What would you like to change about your smile?_____

MEDICAL HISTORY

Physicians Name _____ Date of Last visit _____

Have you had any serious illnesses or operations? (Y/N) _____ If yes, describe _____

Are you currently under medical treatment? (Y/N) _____ If yes, describe _____

Has your physician ever recommended that you take antibiotics prior to your dental visits? _____

(Women) Check (✓) if you are: Pregnant? _____ Due Date _____ Nursing? _____ Taking birth control pills? _____

Check (✓) if you have or have had any of the following:

- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Angina (Chest pain)
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bipolar Disorder
- ☐ Blood Disease
- ☐ Cancer _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Attack _____
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Heart Surgery _____
- ☐ Hemophilia
- ☐ Hepatitis _____
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ Impaired Hearing
- ☐ Impaired Vision
- ☐ IV Bisphosphonate use
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ STDs
- ☐ Steroid treatments
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (Active)
- ☐ Ulcer
- ☐ Other _____

Do you:

- ☐ Smoke tobacco
- ☐ Chew tobacco
- ☐ Use marijuana (recreational or medicinal)
- ☐ Use other drugs _____

MEDICATIONS

Medications you are currently taking:

_____

_____

ALLERGIES

☐Aspirin/Tylenol/Ibuprofen ☐Penicillin ☐Codeine

☐Local Anesthetic ☐Sulfa Drugs ☐Latex

☐Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omission that I may have made in the completion of this form.

Signature _____ Date _____

PATIENT INFORMATION

Today's Date _____

Patient Name _____

Birthdate _____ SSN_____

Status (circle one): Minor Single Married Divorced Separated

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone_____ Work Phone_____

Name of Employer _____

Spouse or Parent's Name_____

Person to Contact in Case of Emergency_____ Phone _____

How did you hear about our office?_____

RESPONSIBLE PARTY **(Person financially responsible for account, if different than above)**

Name _____ Relationship to patient_____

Birthdate _____ SSN_____

Address_____ Phone_____

Name of Employer_____

INSURANCE INFORMATION **(Please provide insurance subscriber's information)**

Name of Insurance Subscriber_____ Relationship to patient_____

Birthdate of Subscriber_____ Social Security Number (required for some insurances to file claims)_____

Subscriber's Employer_____

Insurance Company_____ Group #_____ Member ID # _____

Ins. Co. Address_____

Phone number on card_____

Additional/Secondary Insurance? Yes No (If so, we will provide you with a secondary form for the additional insurance)

HIPAA Privacy Policy

I have been given the opportunity to review the office HIPAA Privacy Policy and am aware that I have access to a copy at any time.

_____ I have read and understand the office HIPAA Privacy Policy
(Initial)

_____ I have been offered a copy of the office HIPAA Privacy Policy
(Initial)

Signature

_____ _____
Patient, parent, or guardian Date

ERIN M. PRACH DDS
CARING GENERAL DENTISTRY

102 N Kenwood, Lower Level
Casper, WY 82601
Ph: (307) 337-4770
Fax: (307) 337-4768
Email: drerin@prachdds.com

Records Release Request

Date: _____

To: _____
(Doctor/Physician)

Address: _____

City: _____ State: _____ Zip_____

Phone: _____ Fax: _____

I authorize the release of my dental records, relevant to dental treatment (x-rays, chart notes, periodontal charts), or copies of such, and request that they be released to:

102 N Kenwood, Lower Level
Casper, WY 82601
Ph: (307) 337-4770
Fax: (307) 337-4768
Please email all records to:
Email: drerin@prachdds.com

Print name of patient Date of Birth

Signature (patient, parent, or guardian)

ERIN M. PRACH DDS
CARING GENERAL DENTISTRY

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Ph: (307) 337-4770
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Email: drerin@prachdds.com

Consent to Perform Dentistry

I hereby authorize Dr. Erin M. Prach to perform the following dental treatment, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:

- Consult with examination for future treatment
- Preventative hygiene treatment (prophylaxis) and the application of topical fluoride
- Application of sealants to the groves of the teeth
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
- Replacement of missing teeth with dental prosthesis (ex. Bridges, partials, dentures)
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissue (hard and/or soft)
- Postponing or delaying treatment at this time

I understand that there are risks involved in this treatment and acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the associated risks.

I understand that the success of the dental treatment to be provided will require that I as the patient or the parent/guardian of a child, follow post care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that office visits scheduled by my dentist and her auxiliaries must be maintained.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I will then be informed of any additional procedures or changes that are deemed necessary for desirable oral health and wellbeing, in the professional judgment of the dentist.

There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of lips, gums, face, and tongue, allergic reaction, hematoma (swelling or bleeding at/or near injection site), fainting, lip or cheek biting resulting in ulceration and infection of mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications causing respiratory depression and/or cardiovascular collapse. (Slow and shallow breathing decreasing oxygen in the body, or a sudden loss of effective blood flow due to heart or vessel factors) and lack of oxygen to the brain that can result in coma or death. I understand and have been informed of the above risks and complications.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I understand and have been informed of the above risks and complications.

I hereby state that I have read and understand this consent, and that all questions about the procedure will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.

Patient's Name: _____

Name of Parent or Guardian (minors only): _____

Signature of Patient or Parent/Guardian: _____

Date: _____

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CARING GENERAL DENTISTRY

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Patient Financial Responsibility

Patient name(s):_____

Payment options:

1. Cash
2. Check and Money Orders
3. All major Credit Cards
4. Care Credit

Initial next to each statement, showing you have read and understand our office policy:

_____ **We will bill your insurance company as a courtesy, but the entire bill is the patient's responsibility.** Our insurance estimates are based on information your insurance provider has given us, and they are **not a guarantee** that your services will be covered. It is up to the patient to resolve any conflicts with their insurance carrier. If the patient is a minor, the custodial parent is legally liable for any bills incurred in this office.

_____ **Payment is due at the time of service**. If we are billing insurance for you, we still ask that you pay your estimated patient portion when services are rendered. We will then send you a statement if there are any amounts outstanding after receiving payment from your insurance carrier.

_____ **We will accept payment of half** the amount of estimated patient portion for dentures, partials, crowns, and bridges on the start date of the procedure. We will collect the second half upon placement or delivery.

_____ **Finance charges** will be applied to any outstanding balance at months end at the rate of 1.80% per month until balance is paid.

_____ **A returned check fee** of $30 will be added to your balance if your check is returned to us. You are responsible for your balance and the returned check fee.

_____ I understand that I am responsible for all debts incurred. If my account is assigned to a collection agency after failure to pay on account, I understand that I am responsible for all attorney fees, court costs, or delinquency fees that may be incurred during the collection of my debt. I understand that the delinquency fee will be equal to 35% of the principal amount owed.

_____ _____

Signature of Responsible Party Date