

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:

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

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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired Vision | <input type="checkbox"/> Steroid treatments |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> IV Bisphosphonate use | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina (Chest pain) | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis (Active) |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Osteoporosis | Do you: |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Smoke tobacco |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chew tobacco |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Use marijuana |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Rheumatic Fever | (recreational or medicinal) |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Use other drugs _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> STDs | |

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 _____

Status (circle one): Minor Single Married Divorced Separated

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse or Parent's Name _____

Person to Contact in Case of Emergency _____ Phone _____

How did you hear about our office? _____

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

Name _____ Relationship to patient _____

Address _____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

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

Name of Employer _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____

Phone number on card _____

Do you know your deductible? _____ How much you have used? _____ Maximum annual benefit? _____

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



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)



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Consent to Perform Dentistry

I hereby authorize and direct Dr. Erin M. Prach D.D.S. to perform the following dental treatment or oral surgery procedure(s), 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 grooves 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)
- Root canals
- Postponing or delaying treatment at this time

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

I will be advised that the success of the dental treatment to be provided will require that the patient and or parents or guardian of patient to 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 the regular office visits are 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.



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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 am also aware that the nose piece used to administer the nitrous oxide/oxygen leaves an indentation or ring around the nose, which disappears shortly after the procedure. 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.

I further more understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____

Name of Parent or Guardian (minors only): _____

Signature of Patient or Parent/Guardian: _____

Date: _____



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Patient Financial Responsibility

Patient's name: _____

Payment options:

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

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 as a courtesy we will ask you pay the estimated patient portion, and we will 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