DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Davidson Family Dental
2624 Commercial Way, Suite C
Rock Springs, WY 82901
P:307-364-4005 F: 3073829764

Date ______ Home Phone (____) ______ Cell Phone (____) ______

PATIENT INFORMATION

Name ______ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # ______

Address ______ E-mail ______

City ______ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______ Occupation ______

Employer/School Address ______ Employer/School Phone (____) ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone (____) ______

PRIMARY INSURANCE

Person Responsible for Account ______ (Last Name / First Name / Middle Initial)

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone (____) ______

Insurance Company ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Birthdate ______ Relation to Patient ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Subscriber Employed by ______ Business Phone (____) ______

Insurance Company ______ Soc. Sec. # ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ (Name of Insurance Company(ies)) and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ Signature of Patient, Parent, Guardian or Personal Representative ______ Date

______ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient

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DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

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

☐ Bad breath ☐ Grinding teeth ☐ Sensitivity to hot

☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets

☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Sensitivity when biting

☐ Food collection between teeth ☐ Sensitivity to cold ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? ______________________ If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ______________________

Phone (_____) ______________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ 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 his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______________________ Signature ______________________

Davidson Family Dental
2624 Commercial Way, Ste. C
Rock Springs, WY 82901
307-362-4005

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all your concerns to your satisfaction before commencing treatment.

During your course of treatment, the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken.

- **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus **above the gum line** and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

- **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled the dental hygienist and dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning **below the gum line**, placement of an antibiotic below the gum line or a gross debridement (two part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

- **RESTORATIONS (FILLINGS)** A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown or both. Sensitivity is a common after effect of a newly placed filling. Occasionally after receiving a filling it may feel high and you may need to return to have the bite adjusted.

- **CROWNS, BRIDGES and VENEERS** It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful chewing on them until the permanent crowns are delivered. If a temporary crown should fall off call the office immediately. The final opportunity to make changes on crowns, bridges or veneers (including shape, fit, size, placement and color) will be done before permanent cementation. In some cases, crowns, bridges and veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown, bridge or veneer is permanently cemented sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleaning procedures may be required and if so will be explained to you by your provider.

- **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)** Symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If need for treatment should arise, you will be referred to a specialist, the cost of which is your responsibility.

Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

A conditional one-year warranty is offered on all dental work subject to the Doctors discretion. To be eligible for warranty work, the patient will be required to make and keep all recommended preventative and periodontal appointments.

Allergies/Medication
I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased using alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Consent
I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

____
Patient Name

____
Patient or Parent/Legal Guardian Signature **Date**

Information Regarding Bisphosphonates

Bisphosphonates are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24th, 2004.

It is very important for you to let us know if you are now, or have ever taken in the past, ANY type of bisphosphonate class drug. If we treat you without knowing if you are now taking, or have taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but may not be limited to) are:

Boniva	**Bonefos**
Skelid	**Didronel**
Fosamax	**Zometa**
Aredia	**Actonel**

Are you now, or have you in the past, taken a bisphosphonate drug, including any of the brands above?

YES__________NO__________DATE__________________________

____
Patient's/Parent/Guardians Signature Date

Davidson Family Dental
2624 Commercial Way, Ste C
Rock Springs, WY 82901
307-362-4005

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient's name:

Payment Options:

1. Cash
2. Checks & Money orders
3. All Major Credit Cards
4. In Office Financing (upon approval)

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we request that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.
Our insurance estimates are based on information provided to us by your insurance carrier, they are in no way a guarantee that services will be covered. Our office is happy to bill your insurance company for you and accept assignment of benefits, but the entire bill ultimately remains the patient's responsibility. It is up to the patient to resolve any conflicts with their insurance company. If the patient is a minor, the custodial parent is legally liable for any bills incurred at this office

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

The estimated patient portion of services rendered is expected on the date of service.
We require at least half of the estimated patient portion for **dentures, crowns, bridges** or any other fixed or removable appliance are paid on the day services are rendered. The remaining half of the estimated patient portion is required on the placement or delivery date.

INSURANCE
We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is happy to bill your insurance company for you and accept assignment of benefits, but the entire bill ultimately remains the patient's responsibility. It is up to the patient to resolve any conflicts with their insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicaid or Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

We will verify patient eligibility status before each scheduled appointment. Without verification of coverage, **you** will be responsible for the **full/entire** balance of your account. As a courtesy to you, your account will be billed to Medicaid, when we receive all necessary information. If you elect to have a procedure done, that Medicaid does not cover, you are responsible for all non-covered portions.

Payment for non-covered benefits will need to be paid before the procedure is performed. No treatment will be rendered until payment is received.

Medicaid only pays for specific procedures based on **age** and **eligibility**. The list of coverage procedures for an adult on Medicaid is very limited.

I understand that I am responsible for all debts incurred that are non-covered benefits by Medicaid.

Finances charges will be applied to any outstanding balance at a rate of 1.50% per month (annual percentage rate of 18%).

I understand that I am responsible for all debts incurred. If my account is assigned to a collection agency, 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 50% of the principal amount owed. Any credits not requested within 2 years will be adjusted to a zero balance and retained by Davidson Family Dental due to additional accounting and billing.

MISSED APPOINTMENTS

We understand how valuable your time is. Therefore, we have set aside time to see you at a specific date and time. However, events sometime come up that require you to change your plans. To avoid a **$50.00** fee, please notify our office 24 hrs. in advance of any changes to your schedule appointment.

A conditional one-year warranty is offered on all dental work subject to the Doctors discretion. To be eligible for warranty work, the patient will be required to make and keep all recommended preventative and periodontal appointments.

____

Responsible party signature Date

Notice of Privacy Practices Davidson Family Dental

THIS NOTICE DESCRIBES HOW DENTAL INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We my contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of intreat to you. Davidson Family Dental agree that we will not post anything on the internet or other publications about our patients. You agree that you will not post anything on the internet or other publications about our office, doctors, or staff. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close friend, or any other person restriction, we must abide by it unless you agree in writing to revoke it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting if disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 12, 2008, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new native provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Humans Service, office of civil rights, about violations of the provisions of the Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

____

Patient/ Guardian Signature Date

Photograph and Publicity Release Form for Social Media

I give my consent to **Davidson Family Dental** to use my name, likeness, image, and/or appearance as such may be embodied in pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of **Davidson Family Dental** activities. I agree that **Davidson Family Dental** has complete ownership of such pictures and may use these pictures for all social media in the present or future. These uses include, but are not limited to **Davidson Family Dental's** Facebook, Instagram, and media. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, and hereby release **Davidson Family Dental** from all claims which arise out of or are in any way connected with such use.

I have read and understand this consent and release.

I give my consent to this form

- O Yes
- O No

Patient Name: ____

DOB: ____

____

Patient/Parent/Guardian Signature

____

Date

NITROUS OXIDE INFORMED CONSENT

I hereby authorize **Davidson Family Dental**
to perform nitrous oxide/oxygen conscious sedation for myself (or my child/ward):

NAME:____

1. I accept and understand that Nitrous Oxide is commonly called laughing gas and provides relaxation. I understand that I (or my child) will be awake, fully conscious, aware of my surroundings, and able to respond rationally to questions and directions.
2. I accept and understand that Nitrous Oxide is an elective procedure and not required to provide the necessary dental treatment. I am aware that the alternative to completing the necessary treatment with Nitrous Oxide is to use local anesthetic ONLY.
3. Please advise the doctor and staff of your complete medical history, including any surgeries. Advise them of any changes in your medical history including if you or your child has a cold, upper respiratory infection, asthma, or difficulty breathing, this may affect how well the nitrous oxide will work.
4. Nitrous oxide sedation is used for anxiety and pain control, as well as control of gagging. Local anesthesia will also be required for most procedures.
5. I have been advised of the possible complications associated with Nitrous Oxide. They include, but are not limited to:
   a) Nausea and vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low.
   b) Temporary tingling in the fingers, toes, cheeks, lips, tongue and head or neck area
   c) Temporary warm feeling throughout the body with accompanying flushing/ blushing.
   d) Temporary detachment or "out of body" sensation.
   e) Temporary sluggishness in motion and/or speech.
   f) Shivering – usually at the end of the procedure.
6. Nitrous oxide sedation is very effective for many people, however; some people may not like the feeling it produces, or it may produce increased activity in some people, at which time you or the dentist may decide to discontinue nitrous oxide sedation.
7. For some people nitrous oxide sedation may not calm them adequately to allow a dental procedure to be done. These people may require referral for other sedation techniques.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and its associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my (or my child's) behalf for a positive outcome from sedation, but no guarantees have been made as to the result of the procedure authorized above.

I give my consent to this form:

O Yes

O No

____________________ ________________________________

Date Patient or Patient's Guardian Signature