DASTRUP DENTAL

DENTISTRY ELEVATED

_____ _____ _____ _____

PATIENT'S NAME PREFERRED NAME DATE OF BIRTH SEX

_____ _____ _____ _____

ADDRESS CITY STATE ZIP CODE

_____ _____ _____

CELL PHONE NUMBER EMAIL SOCIAL SECURITY NUMBER

INSURANCE INFORMATION: *PLEASE GIVE INSURANCE CARD TO FRONT DESK STAFF TO MAKE A COPY*

_____ _____

POLICY HOLDER DATE OF BIRTH

_____ _____ _____

RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER INSURANCE NAME

_____ _____

PREFERRED PHARMACY FOR MEDICATIONS PHONE NUMBER

_____ _____

EMERGENCY CONTACT/ RELATIONSHIP PHONE NUMBER

REFERRED BY: _____

- Do you have any artificial joints or have you had a joint replacement? **YES / NO**

  -IF YES, WHICH JOINT? _____

- Are you required to premedicate with an antibiotic prior to dental treatment? **YES/ NO**

  -IF YES, WHY DO YOU PREMEDICATE? _____

- Have you ever taken Fosamax, or any other Bisphosphonates? **YES/ NO**

- Have you ever had any serious medical trouble associated with any dental experience? **YES/ NO**

  -IF YES, EXPLAIN: _____

- Have you had a serious illness, operation, or hospitalized within the last year? **YES/ NO**

  -IF YES, EXPLAIN:_____

WOMEN: Are you Pregnant, Nursing, or Taking Birth Control? **YES/ NO**

NORMAL BLOOD PRESSURE READING: _____

*Do you **CURRENTLY** take any medications?

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had any of the following diseases or medical problems? ***(Circle all that Apply)***

Abnormal Bleeding
Alcohol/ Drug Abuse
Anemia
Anxiety/Depression
Arthritis
Artificial Bones/ Joints/Valves
Asthma
Blood Transfusion
Cancer/ Chemotherapy
Colitis
Congenital Heart Defect
Diabetes (TYPE I OR TYPE II)
Difficulty Breathing
Emphysema
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Ulcers
Hepatitis (A, B, C, OR D)
Herpes/ Fever Blisters
High Blood Pressure
High Cholesterol
HIV/ AIDS
Kidney Problems
Liver Problems
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Osteoporosis/ Paget's Disease
Pacemaker
Parkinson's Disease
Radiation
Seizures/ Epilepsy
Sinus Problems
Stroke

***Are you Allergic to any of the following:**

Aspirin, Codeine, Penicillin, Latex, Erythromycin, Tetracycline, Local Anesthetics, or Anything Else?

_____

I understand that this information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Physician Name: _____ Phone Number: _____

Dental Questionnaire

How would you rate the condition of your mouth? (Please check the best answer)

Excellent ○ Good ○ Fair ○ Poor ○

Previous Dentist's Name and Number: _____

Date of Last Dental Visit and X-Rays: _____

Do you have any immediate concerns today? **Y/N**

-If Yes, Explain: _____

Are you fearful of dental treatment due to an unfavorable experience? **Y/N**

-If Yes, Explain: _____

Did you ever have braces, or have you had your bite adjusted? _____ What age? ____

On a scale of 1-10, how important is your dental health? _____

Do you expect to keep your teeth during your lifetime? **Y/N?**

Gums and Bone

Do your gums bleed or are they painful when brushing or flossing? **Y/N**

Have you ever been treated for gum disease or have been told you've lost bone around your teeth? **Y/N**

Do you notice you have bad breath or do you have a bad taste in your mouth? **Y/N**

Tooth Structure

What dental work have you had in the past three years?

_____

_____

Does the amount of saliva in your mouth feel too little? **Y/N**

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?

_____

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? **Y/N**

Do you frequently get food caught between your teeth? **Y/N**

Do you have any grooves or notches on your teeth near your gum line? **Y/N**

Do you clench or grind your teeth together during the daytime or make them sore? **Y/N**

Do you wake up with a headache or awareness of your teeth? **Y/N**

Do you or have you worn a bite appliance? **Y/N**

Smile Characteristics

Rate your smile: (circle one)

What would you want to change? _____

Have you been disappointed with the appearance of previous dental work? _____

_____

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) **Y/N**

Are you concerned about crowding or spacing of your teeth? **Y/N**

Do you have trouble finding your bite, or need to shift your jaw to make your teeth come together?
_____

Do you notice your teeth changing? (Becoming shorter, thinner, or worn, or moving) **Y/N**
_____

Have you ever been told that you snore? **Y/N**

How many times do you routinely wake up during the night? _____

Do you breathe through your nose? **Y/N**

Insurance:
Our fees are determined by our ability to provide you with the highest level of care, skill, and judgment a particular procedure may require. As a courtesy to our patients, we will verify your insurance benefits. Please remember that this is an estimate of coverage based on the most up to date information we have, but it is only an estimate. If insurance does not pay within 60 days, we will be happy to re-file or submit any additional information to support your claim. It is important to recognize that the insurance you have is a legal contract between you and your insurance company. Ultimately you are responsible for all charges incurred in our office and for any balance that is not covered by insurance. We ask you to pay us for services as rendered and be reimbursed directly from your insurance company. If you do not receive payment in a timely fashion, please call your insurance company to determine the status of your claim.

Financial Arrangements:
We are committed to helping our patients get the necessary treatment without financial restrictions. We have several financing options available to help you reach your oral health goals. If insurance pays more than expected, we will reimburse you or credit your account for future dental needs. If insurance doesn't pay what we anticipated, it will be your responsibility to pay the balance. Please remember insurance is a benefit and it wasn't designed to cover the entire balance.

Appointments:
In order to provide the best quality of care, we kindly ask that you give us a minimum of a 48 hours' notice if you need to change an appointment. We understand that emergencies happen. Dr. Dastrup and his team want to be available for your needs and the needs of all of our patients therefore if you are more than fifteen minutes late to your appointment, we may have to reschedule you. Thank you for being a valued patient and for your understanding.

HIPAA Acknowledgement:
I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that received this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by recipient and, if so, may not be subject to federal or state laws protecting its confidentiality.

Authorization and Release:
I authorize Dastrup Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third parties/ or other health practitioners. I also authorize Dr. Dastrup to take digital photography to help educate patients on specific dental needs. Photographs will never include your name or face and are solely used for educational purposes.

Photography:
Digital Photography in our office is necessary to help document your dental history and explain future treatment. These photographs may be used for educational purposes including helping educate other patients on specific dental treatments. We also love taking before and after photos of smile transformations to share on social media and our office webpage**. Photographs will never include your name or face without further consent.**

Signature_____ Date_____

HIPPA and Notice of Private Practices

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the uses or disclosures made pursuant to an authorization requested by an individual. Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency. The full version of the Notice of Privacy Practices is available at the front desk for your viewing and our website. Please let us know if you would like a copy to take home.

I wish to be contacted in the following manner:

☐ Cell phone ☐ Mail to my home address ☐ Mail to my work/office address ☐ Email

☐ Other_____

☐ Leave message with detailed information ☐ Leave message with call back number only

Permission to disclose information form:

I allow Dastrup Dental and staff to discuss my medical information with:
_____ relationship
_____relationship
_____ relationship

☐ I request that my medical information not be shared with anyone other than another medical provider or a pharmacy. By signing this document, I agree to all of the above.

Patient Signature _____Date: _____

Print Name _____