Deluxe Dental
DENTISTRY FOR KIDS & ADULTS
Phone: (248) 274-4020

How Did You Hear About Us?

- [ ] Drive By/Walk in
- [ ] Family/friend
- [ ] Internet (Google, Facebook, etc.)
- [ ] Another Dental Office
- [ ] Hurley Hospital
- [ ] 1-800-Dentist
- [ ] Insurance company
- [ ] Other

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Patient Information

How did you hear about us? _____

Last Name _____

First Name _____

Address _____

City _____ State _____ Zip Code _____

☐ Male or ☐ Female (Check One)

Patients D.O.B _____

Age _____

Phone Number _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Email. _____

Social security number _____

When was the last time you were seen by a Dentist? _____

I assume full responsibility for all dental work performed. The completion of all dental insurance forms is a service which the dental office offers, however, the final responsibility for collection from the insurance company is mine. I assign benefit payment to the above dental office for treatment performed while a patient at this office.

_____ _____

Signature Date

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Health History

Patient's Name _____ Date of Birth _____ Weight _____ Date _____

Answer all questions by checking Yes (Y) or No (N)

1. Are you in good health? ☐Y ☐N
2. Has there been any change in general health in the past year? ☐Y ☐N
3. Date of last physical exam: _____
4. Are you now under a physician's care for a particular problem? ☐Y ☐N
5. Have you ever had any serious illnesses, hospitalizations, or operations? If so, describe: ☐Y ☐N

6. Do you have any problems OR have you been told you stop breathing while sleeping OR you snore? ☐Y ☐N
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Congenital Heart Disease? ☐Y ☐N
   - B. Cardiovascular Disease (Heart Attack, Arteriosclerosis, Coronary Artery Disease, Angina, Stroke, palpitations, Heart Surgery)? ☐Y ☐N
   - C. Artificial heart valves, artificial Joints (hip replacement, knee replacement, etc.)? ☐Y ☐N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐Y ☐N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ☐Y ☐N
   - F. Bleeding disorder, anemia, bleeding tendency, Blood Transfusion? Do you bruise easily? ☐Y ☐N
   - G. Liver Disease (Jaundice, hepatitis)? ☐Y ☐N
   - H. Kidney Disease? ☐Y ☐N
   - I. Diabetes? ☐Y ☐N
   - J. Thyroid Disease (Goiter)? ☐Y ☐N
   - K. Arthritis? ☐Y ☐N
   - L. Stomach Ulcers or Colitis ☐Y ☐N
   - M. Glaucoma? ☐Y ☐N
   - N. Osteoporosis? ☐Y ☐N
   - O. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or cancers (Reclast, Fosamax, Actonel, Bonlva, Zometa)? ☐Y ☐N
   - P. Cancer? Type? _____ ☐Y ☐N
   - Q. Radiation (X-ray) treatment for Cancer? ☐Y ☐N
   - R. Chemotherapy? ☐Y ☐N
   - S. Clicking or popping of jaw Joint, pain near ear, or difficulty opening mouth? ☐Y ☐N
   - T. Clench or grind your teeth? ☐Y ☐N
   - U. Sinus or Nasal problems? ☐Y ☐N
   - V. Any disease, drug, or transplant operation that has depressed your immune system? ☐Y ☐N
   - W. HIV/AIDS? ☐Y ☐N

8. ARE YOU USING ANY OF THE FOLLOWING
   - A. Antibiotics ☐Y ☐N
   - B. Anticoagulants (Blood thinners) ☐Y ☐N
   - C. Aspirin or drugs such as Motrin, Aleve, ibuprofen? ☐Y ☐N
   - D. High Blood Pressure medications? ☐Y ☐N
   - E. Steroids(CortisOne, Prednisone, etc.)? ☐Y ☐N
   - F. Insulin or Oral Anti-Diabetic drugs? ☐Y ☐N
   - G. Digitalis, Inderal, Nitroglycerin or other heart drugs? ☐Y ☐N
   - H. Have you ever been advised NOT to take a medication? ☐Y ☐N
   - I. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, or holistic remedies, vitamins or minerals:

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia? ☐Y ☐N
   - B. Penicillin or other antibiotics? ☐Y ☐N
   - C. Aspirin or Ibuprofen? ☐Y ☐N
   - D. Codeine or other pain killers? ☐Y ☐N
   - E. Latex or Rubber? ☐Y ☐N
   - F. Metal of any kind? ☐Y ☐N
   - G. Chemicals or Jewelry (rash or sensitivity)? ☐Y ☐N
   - H. Food products? ☐Y ☐N
   - I. Other allergies or reactions? Please list:

10. Do you smoke or chew tobacco? ☐Y ☐N
    How much per day?_____
11. Is there any past History of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide? ☐Y ☐N
12. Have you had any serious problems associated with any previous dental treatment? ☐Y ☐N
13. Do you have any other disease, condition or problem not above that you think the doctor should know about? ☐Y ☐N
14. Do you wish to talk to the doctor privately about anything? ☐Y ☐N
15. FOR WOMEN ONLY:
    - A. Are you (potentially) Pregnant? ☐Y ☐N
    - B. Are you nursing? ☐Y ☐N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some others may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

I understand be importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date _____ Signature of Person Completing Health History _____ Doctor's Signature _____

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Informed Consent

Please read and initial the following. If you have any questions, please ask your doctor.

1. Preliminary consent for treatment:

I understand I am having any and all of the following done today; exam, x-ray, and cleaning.

_____
Initials

2. Medications, substance and medical conditions

I understand the antibiotics, analgesic (pain medicines), anesthesia, lates, and other substances can cause allergic reactions, resulting in redness and swelling of tissue, itching, pain, trouble breathing, and/or vomiting. I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy.

_____
Initials

3. Changes to treatment plan

I understand that during treatment it may be necessary to change or add procedures because of the condition found during treatment that was not evident during initial examination. Some changes are but not limited to root canal therapy that is necessary following the placement of a "deep filling" or crown. I authorize my dentist to make any changes to my treatment plan when necessary.

_____
Initials

4. Dental benefits

I understand that treatment that my dentist recommends is based on what she/he determines is best for my dental health, and not necessarily based on what the insurance will pay for. Therefore, I understand that my insurance may not cover all aspects of my treatment plan. I understand the treatment plan proposed to me is an estimate of coverage. I also acknowledge that I am responsible for any balance remaining in event that my insurance coverage is terminated for any reason.

_____
Initials

I understand dental treatment has potential risks and consequences. Likewise so does the refusal or denial of treatment. Untreated conditions may lead to pain, swelling, infections, tooth loss, and/or severe consequences. I understand that dentistry is not an exact science and that no exact result can be assured or guaranteed. I have had the opportunity to have all my questions answered by my dentist.

_____ _____
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Acknowledgment of Privacy Practice

You may refuse to sign this acknowledgement

I, _____received a copy of the office's notice of privacy practices.

_____ _____
Signature Date

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy Practices acknowledgement could not be obtained because:

☐ Refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ Other: _____

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HIPPA Office Policy

Health insurance portability and privacy act prohibits us from faxing, emailing, or sharing personal information over the internet. For the safety of the patient, all personal patient matters can be dealt with in person or over the phone with the patient/guardian.

Signature _____ Date _____