



Patient Information

Patient Name: _____

Address: _____ City _____ Zip _____

Home# _____ Work# _____ Cell# _____

Email: _____

Occupation: _____ Employer: _____

Height _____ Weight _____ Date of Birth _____ Sex: M F

SS# _____ Referred by: _____

Emergency Contact: _____ Phone# _____

Responsible Party

Name: _____ Relationship: _____

Address: _____

Home# _____ Work# _____

Insurance Policy

Name of Insured: _____ Date of Birth _____

SS# _____ Employer: _____

Insurance Company: _____

Dental Questionnaire

When was the last time you had your teeth cleaned? _____

When was the last time you had dental work? _____

Have you ever had periodontal (gum) treatment?	Yes	No
Do you floss regularly?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Have you ever been concerned about bad breath?	Yes	No
Do you consistently get a bad taste in your mouth?	Yes	No

What are your dental goals? _____

Sleep Health Questionnaire

Do you feel tired throughout the day?	Yes	No
Do you wish you slept better and had more energy?	Yes	No
Have you ever been told you occasionally snore or do you snore?	Yes	No
Have you or a loved one been prescribed a CPAP?	Yes	No

Patient Medical History

1. Have you ever been seriously ill or diagnosed with cancer? Yes No
 If yes, please explain. _____
- Have there been any changes in your general health lately? Yes No
 If yes, please explain. _____
3. Is a medical doctor currently treating you? Yes No
 If yes, who & please explain. _____
4. Please list any medications you take. _____
5. Have you ever had major operation or been hospitalized? Yes No
 If yes, please explain. _____
6. Have you had a physical exam within the last year? Yes No
7. Have you ever had to take antibiotics (**PRE-MED**) before having dental work? Yes No
8. Do you have chest pains upon exertion? Yes No
9. Have you ever had x-rays for a tumor, growth, or other condition? Yes No
10. Please circle any from the list below that you are allergic to or have had reaction to:
- | | | | | |
|--------------|-------------------|---------|--------------|-------|
| Penicillin | Erythromycin | Codeine | Aspirin | Latex |
| Sulfa drugs | Local anesthetics | Iodine | Barbiturates | |
| Other: _____ | | | | |
11. Are you currently using any recreational drugs? Yes No
12. Had you ever had a blood transfusion? Yes No
13. Do you have shunts for dialysis or any other condition? Yes No
14. Do you bleed for a long time when you cut yourself? Yes No
15. Do you have frequent or severe headaches? Yes No
16. Do you have sinus trouble? Yes No
17. Do you have painful or swollen joints? Yes No
18. Do you have frequent cold sores or mouth ulcers? Yes No
19. Do you have complaints about your ears/hearing? Yes No
20. Do you have frequent colds? Yes No
21. Do you use tobacco? Yes No
22. Are you nervous? Yes No
23. Have you ever had or now have any of the following diseases or problems:
- | | | | | | |
|-----------------------|-----|----|----------------------|-----|----|
| Mitral Valve Prolapse | Yes | No | Kidney Disease | Yes | No |
| High Blood Pressure | Yes | No | Arthritis | Yes | No |
| Low Blood Pressure | Yes | No | Epilepsy | Yes | No |
| Heart Attack | Yes | No | Abnormal Bleeding | Yes | No |
| Heart Murmur | Yes | No | Jaundice | Yes | No |
| Diabetes | Yes | No | Rheumatic Fever | Yes | No |
| Asthma | Yes | No | Tuberculosis | Yes | No |
| Hepatitis | Yes | No | Venereal Disease | Yes | No |
| Seizures | Yes | No | Hives/Skin Rash | Yes | No |
| Stroke | Yes | No | Artificial Bones | Yes | No |
| AIDS (HIV) | Yes | No | Difficulty Breathing | Yes | No |
| Anemia | Yes | No | Pace Maker | Yes | No |

For Women Only (questions 1-3)

1. Are you currently pregnant or suspect you may be pregnant? Yes No
 If yes, how far along are you? _____
2. Are you currently nursing? Yes No
3. Are you taking birth control pills or hormonal replacement? Yes No

 All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. Please carefully review the above medical history you have provided before signing.

I have read and understand the above questions. I have answered all these questions truthfully to the best of my ability and knowledge.

Signature _____ Date _____



Welcome to Our Practice!

Thank you for choosing our office for your dental care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

Financial Agreement

- I understand that payment for services is completely my responsibility.
- **I understand that my insurance is an agreement between the insurance company and myself and not between Dr. Venet and the insurance company.**
- We file insurance as a courtesy.
- We gladly accept and file most insurances. We are only in network with Delta Dental.
- I must provide the correct dental insurance information for this office to accept insurance as a payment.
- If insurance cannot be verified or if I do not have insurance, I will pay in full with cash, check or credit card at time of service.
- I also understand that I am responsible for any balance over 30 days.
- I understand that if for any reason my account is turned over to a collection agency, I will be responsible for any and all fees to collect my balance.

Appointments

In order to give the most efficient care; we work within an appointment system. Our office hours are Monday through Thursday, 8am to 5pm. (Closed for lunch 1-2pm.) We make every effort to honor all time commitments and expect patients extend us the same courtesy. We are available when emergencies arise, and will do our best to give prompt consideration as needed. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment.

Cancellation Policy

I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least 24 hours in advance of my scheduled appointment time. I understand that I should call the office and confirm my appointment within 24 hours. Please note schedule changes will be accepted during regular office hours. **I am aware that I may be charged a fee if I do not provide 24 hours notice of cancellation or do not show up for the appointment.** The fee will vary depending on the amount of time scheduled and will not be less than \$50.00. If you fail to show up for two appointments, we may not be able to schedule you any more appointments.

Parents

You may accompany children in the operatories by invitation only. However, we do require you remain in the building with minor children (under 18 years of age) for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

I CERTIFY THAT I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

Patient Name (please print): _____

Patient/Guardian Signature: _____ Date: _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Mailing Address: _____

Venet Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail (Provide phone numbers that we can leave messages to)	<input type="checkbox"/> Financial <input type="checkbox"/> Dental <input type="checkbox"/> Appointment reminders
<input type="checkbox"/> Other person (s) (Provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Dental
<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Dental <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
*For email communication to occur, please accept the disclosure below:	
<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
*For text communication to occur, accept the disclosure below:	
<input type="checkbox"/> For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative’s Authority (attach necessary documentation)



**Acknowledgement of Receipt
Of Notice of Privacy Practices**

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

- Other: _____

Prepared By _____

Signature _____

Date _____
