Date____/____/_____

PATIENT MEDICAL HISTORY

PATIENT INFORMATION → PLEASE COMPLETE ALL INFORMATION			
First Name:	Middle Name:	Last Name:	Previous Last Name:
Date of Birth: / /	Sex: □ M □ F	Height:	Weight:
Referred By:			

DENTAL HISTORY		
Chief Dental Complaint(s): When was the last time you saw a dentist/hygienist?		Are you currently having problems with dental pain or pain management? □ Yes □ No If yes, using a scale from 1-5, with 5 being the worst, please rate your pain. 1 2 3 4 5
Have you had any serious trouble associated with previous dental treatment?	Do you have: □ Natural Teeth □ Dentures	How often do you brush? How often do you floss?

MEDICAL HISTORY		
Please inform our receptionist immediately if you have any of the following conditions: uncontrolled high blood pressure, pregnancy or conditions requiring pre-treatment antibiotics.		
Are you in good health? □ Yes □ No	Has there been any change in your general health within the past year? □ Yes □ No	Are you now under the care of a physician? □ Yes □ No
Physicians Name: Address: Phone: ( )	Have you had any serious illnesses or operations? □ Yes □ No If yes, what was the illness or operation?	**Women:** Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Do you have any problems associated with your menstrual period? □ Yes □ No

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS:		
□ Antibiotics or sulfa drugs □ Anticoagulants (blood thinners) □ Medicine for high blood pressure □ Cortisone (steroids) □ Tranquilizers □ Antihistamines □ Aspirin	□ Insulin, Tolbutanide (Orinase) or similar drugs □ Digitalis or drugs for heart □ Nitroglycerin □ Oral contraceptives/other hormonal therapy	□ Other (list any medications you are taking): □ **I am not taking any medications**

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:	
□ Local anesthetic □ Penicillin or other antibiotics □ Sulfa drugs □ Barbiturates, sedatives, or sleeping pills □ Latex	□ Aspirin □ Iodine □ Codeine or other narcotics □ Other (list any other allergies not listed): □ **No known drug allergies**

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Athena/Dentrix entry & verification: ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (ANSWER EACH QUESTION Y/N)					
	Y	N		Y	N
DAMAGED HEART VALVES OR ARTIFICIAL HEART VALVES, INCLUDING MURMUR			SEXUALLY TRANSMITTED DISEASES IF YES; □ GONNORRHEA □ SYPHILIS □ GENITAL HERPES		
CONGENITAL HEART LESIONS			PSYCHIATRIC/EMOTIONAL DISORDER		
CARDIOVASCULAR DISEASE, HEART TROUBLE, HEART ATTACK, CORONARY INSUFFICIENCY			CANCER OR LEUKEMIA IF YES, WHAT TYPE?		
CORONARY OCCLUSION, HIGH BLOOD PRESSURE, ARTERIOSCLEROSIS, STRESS			AIDS OR OTHER IMMUNOSUPRESSIVE DISORDER? IF YES; CD4: VL:		
ARE YOU EVER SHORT OF BREATH AFTER MILD EXERCISE?			NEUROLOGICAL PROBLEMS		
DO YOUR ANKLES SWELL?			STROKE		
DO YOU GET SHORT OF BREATH WHEN YOU LIE DOWN?			HAVE YOU HAD ABNOMRAL BLEEDING WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA?		
DO YOU REQUIRE EXTRA PILLOWS TO SLEEP?			DO YOU BRUISE EASILY?		
DO YOU HAVE A CARDIAC PACEMAKER?			HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF YES, EXPLAIN CIRCUMSTANCES:		
ALLERGIES, SINUS TROUBLE, ASTHMA OR HAY FEVER, HIVES OR SKIN RASH			BLOOD DISORDERS SUCH AS ANEMIA OR SICKLE CELL DISEASE		
FAINTING SPELLS, SEIZURES OR EPILEPSY			DO YOU CONSUME ALCOHOL? IF YES, FREQUENCY:		
DIABETES IF YES; □ DO YOU HAVE TO URINATE MORE THAN 6 TIMES A DAY □ ARE YOU THIRSTY MUCH OF THE TIME □ FREQUENT DRY MOUTH			DO YOU SMOKE CIGARETTS OR USE SMOKELESS TOBACO? HAVE YOU EVER USED DRUGS FOR RECREACTIONAL PURPOSES (COCAINE, MARIJUANA, PRESCRIPTION DRUGS)? HIGH OR LOW BLOOD PRESSURE		
HEPATITIS, JAUNDICE OR LIVER DISEASE			PERSISTENT COUGH OR COUGH UP BLOOD		
ARTHRITIS OR INFLAMMATORY RHEUMATISM			HAVE YOU HAD SURGERY, X-RAYS OR DRUG TREATMENT FOR A TUMORE GROWTH OR OTHER CONDITION OF YOUR HEAD OR NECK?		
STOMACH ULCERS OR KIDNEY PROBLEMS			TUBERCULOSIS IF YES, WHEN?		
DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT THE DENTIST SHOULD KNOW ABOUT?					

I certify that I have read and understand the above, and that the information I provided is accurate. I understand the importance of an honest health history and that my dental providers will rely on this information to treat me. I will not hold my dentist or any member of the dental staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient/Legal Guardian Date Signature of Dentist Date

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Athena/Dentrix entry & verification: ____

Date____/____/_____

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION → PLEASE COMPLETE ALL INFORMATION				
First Name:	Middle Name:	Last Name:	Previous Last Name:	
Is this your legal name? □ Yes □ No	**If no**, what is your legal name?	Social Security #	Date of Birth: / /	Sex (at birth): □ M □ F
Home Address:		City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )		Mobile Phone: ( )	
Email Address:		Contact Preference (check all that apply): □ Home □ Work □ Mobile to include □ calls □ texts		
Marital Status: □ Single □ Widowed □ Married □ Separated □ Divorced □ Partnered Pharmacy preference (w/location):	Language: □ English □ Spanish □ Other: _____ □ Require Translator (sign language requires advanced notice)	Race (check all that apply): □ African American/Black □ Asian □ American Indian/Alaskan Native □ Native Hawaiian □ Pacific Islander □ Caucasian/White □ Do not wish to report	Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino □ Do not wish to report	
Emergency Contact:		Emergency Contact Phone Number: ( )	Relationship:	
Employment: □ Employed □ Unemployed: if so, check one □ Full Time □ Part time □ Student □ Disabled □ Retired □ Seeking employment □ Self Employed □ none of the above		Occupation/ Employer:	Student Status: □ Full Time □ Part Time	

BECAUSE THIS OFFICE IS A COMMUNITY HEALTH CENTER THE INFORMATION IN THIS SECTION MUST BE DOCUMENTED AND UPDATED ANNUALLY:

Sexual orientation: ☐ heterosexual ☐ homosexual ☐ bi-sexual ☐ trans-sexual ☐ other ☐ choose not to disclose

Gender identity: ☐ male ☐ female ☐ bi-sexual ☐ transgender male to female ☐ transgender female to male ☐ gender queer ☐ other ☐ choose not to disclose

Sliding Fee application up to date? □ Yes □ No
Do you consider yourself Homeless? □ Yes □ No
Are you a Migrant/Seasonal Worker? □ Yes □ No
Are you a Veteran of the Uniformed Services of the United States? □ Yes □ No □ Unsure

Name of Guarantor (person responsible for this bill):		Mailing Address of Guarantor:	
Phone Number of Guarantor: ( )		Guarantor's Date of Birth: / /	Guarantor's SSN:
DENTAL INSURANCE INFORMATION → PLEASE HAVE INSURANCE CARD(S) AVAILABLE			
Primary Insurance Company Name & Phone No:		Policy Number/Member ID:	Group Number & Employer:
Policy Holder's Name:	Policy Holder's SSN:	Policy Holder's Date of Birth: / /	Relationship to Patient:
Secondary Insurance Company Name & Phone No:		Policy Number/Member ID:	Group Number & Employer:
Policy Holder's Name:	Policy Holder's SSN:	Policy Holder's Date of Birth: / /	Relationship to Patient:
If additional insurance sources exist, please notify Patient Services Representative during registration.			

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Who is your primary caregiver? □ self □ if not self, caregiver name: _____

Is the above person your legal guardian? □ Yes □ No

Caregiver/legal guardian address and phone number (if applicable): _____

I AUTHORIZE TANDEM HEALTH DENTAL TO DISCUSS MY DENTAL/MEDICAL/FINANCIAL INFORMATION WITH:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

PLEASE LIST ANY OTHER DENTAL/MEDICAL PROVIDERS YOU SEE:

Specialty (if any):	Specialty (if any):
Name:	Name:
Phone Number:	Phone Number:

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES FOR TANDEM HEALTH SC:

_____ _____

Signature of Patient or Legal Guardian **Date**

IF ADDITIONAL SPACE IS REQUIRED, CONTINUE ON AN ADDITIONAL SHEET OF PAPER:

The above information is true to the best of my knowledge.

I authorize my insurance benefits to be paid directly to the practice, and authorize use of this signature on all my insurance claims. I understand that the dollar amount I am asked to pay at the time of service is an estimate and may vary from my final balance due after my insurance has processed my claims.

I understand that I am responsible for knowing and understanding my insurance benefits, and will be billed for any balances left after my claims have processed. I agree to pay any residual balance on the account after insurance processing is complete.

I authorize Tandem Health Dental or my insurance company to release any information required to process my claims. I also authorize Tandem Health Dental to release and/or request release of my dental/medical information as it relates to the information disclosed on this form.

_____ _____

Signature of Patient or Legal Guardian **Date**

I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.

CONSENT FOR TREATMENT

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Tandem Health Dental. These procedures include, but are not limited to; examinations, x-rays, photographs, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns) periodontal (gum) treatments, endodontic (root canal) treatments, extractions, use of conscious sedation (nitrous oxide/"laughing gas") and local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reactions, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____

Signature of Patient or Legal Guardian **Date**

THIS SECTION TO BE COMPLETED FOR CHILDREN UNDER THE AGE OF 18 BY A PARENT OR LEGAL GUARDIAN

I affirm that I am the parent or legal guardian for the above named minor children *(under the age of 18)*. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Name: _____

□ Since my child is 16 years of age or older, I also give permission for him/her to receive treatment when unaccompanied by an adult. I understand that no invasive treatment such as extractions or initiation of root canal therapies will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating Provider.

_____ _____

Signature of Patient or Legal Guardian **Date**

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Tandem Dental
Missed Appointment Policy

_____ _____

Print Patient Name Birth Date

We value our patients and the time they set aside to receive their dental care with us. Dental care is a scarce resource, and we have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill the appointment with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

Broken Appointments: Patients are only allowed THREE missed appointments in a calendar year.

- Missed appointments are any time you are scheduled for an appointment and you do not show for that appointment.
- Late cancelations are considered missed appointments. If you need to cancel or reschedule your appointment, we ask that you call us at least 24 hours before your appointment time.
- Late arrivals are also considered missed appointments. If you do not arrive within 10 minutes after the start time of your appointment, it may be rescheduled if we do not have adequate time to complete your procedure.

Appointment Confirmation: We request that you utilize our appointment reminder service, "Well Messenger", to confirm your appointments via text or phone, or that you call our office the day before your appointment to confirm with our staff.

If for any reason, a patient misses their appointment or cancels late for a third time within a calendar year, they will not be *scheduled* another appointment. However, these patients are welcome to receive their care on a walk-in basis. Patients who have missed three appointments within a calendar year, can either call us in the morning for a "same day appointment," or they may attempt to come in as a "walk-in patient." We will do our best to work our walk-in patients into the schedule, as long as it does not interfere with the care of previously scheduled patients. Please understand that there is no guarantee that "walk-in" patients will be seen on any given day, and may have to try again another day. Walk-in patients may also experience longer wait times than scheduled patients.

Patient Commitment & Acknowledgement: I have read and understand the 'Missed Appointment Policy', and will make my dental appointments a priority

_____ _____

Patient/Guardian Signature Date