MEDICAL HISTORY

FOR

_____ _____

Birth Date

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Registration Forms

Patient Information:

Patient First Name:_____ Last name: _____ M.I. :___

Patient Phone (hm/cell / wk) : _____Patient Email: _____

DOB:_____ SSN:_____Gender: (M : F) circle one

Home Address: _____City _____ST:_____ Zip_____

When confirming appointments, ways you'd like to be reached: ❑ Home❑ Cell❑email or ❑ Other _____

Emergency Contact:

Name: _____ Phone #: _____ Relationship to patient: _____

Name: _____ Phone #: _____ Relationship to patient: _____

If Patient Under 18, Please Complete This Section for Responsible Party

First Name: _____Last Name:_____ Relationship to pt. :_____

Phone #: _____ DOB: _____ SSN: _____

Employer:_____Email address: _____

Home Address: _____ City _____ST:_____ Zip_____

Insurance Information

Insurance Company:_____ Phone number: _____

Policy holder's Name:_____ Policy ID#/SS:_____

Employer: _____

General Information:

(Print) Name of person to authorize release of account & personal information to:

First Name:_____ Last Name: _____

Relationship to patient: _____

Last dental exam:_____ How did you hear about us: _____

Concerns you would like to address today: _____

By signing, I acknowledge that I have answered all questions above accurately & to the best of my knowledge.

Signature of Patient, Parent or Guardian_____ Date: _____

Brian C. Pratt, D.D.S., P.A.

Dental and Orthodontic Center of Lake Conroe

15260 HWY 105 West, Suite 222

Montgomery, TX 77356

Authorization for signature on file/ Authorization of payment/

Release of information/Financial responsibility

I _____ understand and agree that I am responsible for all charges incurred regardless of my insurance coverage. I understand that Brian C. Pratt, DDS, PA has accepted the insurance company's verification and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that my insurance company does not cover the claim for the verified benefits, I agree to the responsibility for all charges for dental services and materials which I and/ or my dependents have incurred and authorized in my and/ or my dependents treatment. I agree that any balance not paid by my insurance company within 60 days will be my responsibility to pay. I agree to furnish my insurance company and Dr. Pratt with any additional information or paperwork requested to expedite payment of my claim. The extent permitted under applicable law, I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Brian C. Pratt, DDS, PA. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services to me or my dependents as if I had signed each benefit assignment on future claims.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Brian C. Pratt, DDS, PA.

_____ _____

Today's Date Signature of Insured

Dental Treatment Consent Form

Drugs and Medications: I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe life threatening allergic reaction). I have informed Dr. Pratt of any known allergies. I have truthfully revealed all aspects of my health history. I understand that numbness or altered sensation in the teeth, lip, tongue, and chin due to bruising or injury to the nerves can occur during injection of anesthetics. Most often the sensation returns to normal, but in very rate cases, the loss may be permanent.

Changes in Treatment Plan: I understand that during treatment it may be necessary to change or modify procedures due to conditions found while working on the teeth that were not evident during initial examination.

Bleaching

Bleaching is a procedure done with take-home trays. The degree of whitening varies with each patient, but the average patient achieves considerable change. Coffee, tea, tobacco, and other substances will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. Dr. Pratt may prescribe fluoride treatments for rare cases of persistent hypersensitivity. Bleaching agents have unknown risks and acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before considering bleaching.

Nitrous Oxide

I have been informed and understand possible side effects that may occur if I elect to have nitrous oxide in conjunction with my dental treatment. These include, but not limited to nausea, vomiting, dizziness, and headache. I also understand that nitrous oxide use is not indicated if I am pregnant.

Fillings

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include a root canal, crown, or both. I understand that sensitivity is a common after effect of a newly placed filling or restoration.

Crowns and Veneers

Treatment involves covering the tooth with a cap (crown) or covering the front surface of the tooth with a tooth colored bonded porcelain laminate called a veneer. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, size, fit, and color) will be before final cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delay may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer and could result in further treatment. I understand there will be additional fees for remakes or other treatment due to my delaying permanent cementation or delivery of the appliance.

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that there is no guarantee that has been made by anyone regarding dental treatment. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I am capable of understanding English or I have provided for a translator.

_____ _____

Signature of Patient/Parent/Guardian Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Dental and Orthodontic Center of Lake Conroe; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____

Signature of patient or parent/legal guardian/legally responsible person

_____

Date

_____

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- o Patient/personal representative refused to sign form
- o Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

- o Form mailed/sent to patient/personal representative on (date): _____

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____

Signature of staff member Date