PATIENT LAST NAME:_________________________________ FIRST: ___________________________INITIAL: __________

SSN:_________________________DOB:__________________ Marital Status: □ Single □ Married □ Widowed □ Divorced

Address:____ City__________________ State________ Zip ____________

Telephone (Mobile)_________________________(Work)______________________ (Home) _______________________

Email ___________________________________ How did you hear about our practice? ____________________________

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name ___________________________________	Subscriber Name ___________________________________
Subscriber ID ________________Date of Birth _____________	Subscriber ID ________________Date of Birth _____________
Relationship to Subscriber □ Self □ Spouse □ Child □ Other	Relationship to Subscriber □ Self □ Spouse □ Child □ Other
Employer Name ____________________________________	Employer Name ____________________________________
Employer Phone ____________________________________	Employer Phone ____________________________________
Insurance Company _________________________________	Insurance Company _________________________________
Insurance Group ___________________________________	Insurance Group ___________________________________
Insurance Phone___________________________________	Insurance Phone___________________________________

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If minor)

Last Name: _______________________________________First: _____________________________Initial: _____________

Address (If different):____ City _______________ State______ Zip__________

Telephone (Home)________________________ (Work)______________________ (Mobile)___________________________

EMERGENCY CONTACT

Last Name: ____First: ___________________________Initial: _____________

Telephone: □ Mobile ___________________________ □ Work______________________ □ Home _____________________

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. It is your responsibility to know your individual coverage and its limitations, as well as who is a provider of your plan. Depending on the services needed, some providers are in or out of network. We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether the doctor you are seeing is either in or out of network for your specific dental needs with your insurance.

I hereby give my consent to the dentist to perform an examination, diagnostic x-rays and diagnose my condition. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist. I attest to the accuracy of the information on this page.

Signature of Patient ____ Date ________________

(Patient or Parent/Guardian if minor)

LAST NAME: ____ **FIRST NAME:** ________________________________

DENTAL HISTORY

Reason for today's visit ____ Date of last dental visit ____________________

Previous Dentist: ____ Phone Number: __________________________

Please check if you have/had:

- □ Bad breath
- □ Blisters on lips or mouth
- □ Burning sensation on tongue
- □ Chew on one side of mouth
- □ Cigarette, pipe, or cigar smoking
- □ Smokeless tobacco
- □ Dry mouth
- □ Food collection between teeth
- □ Clench or grind teeth
- □ Difficulty opening or closing jaw
- □ Difficulty in chewing food
- □ Growths or sore spots in your mouth
- □ Gums swollen, tender or bleeding
- □ Head, neck, jaw pain, or aches
- □ Lip or cheek biting
- □ Loose teeth or broken fillings
- □ Mouth breathing
- □ Nitrous Oxide
- □ Orthodontic treatment
- □ Periodontal treatment
- □ Sensitivity to pressure or irritants (cold, heat, sweets, sour)
- □ Tooth Pain
- □ Wear dentures or partials

How often do you floss? __________________________

How often do you brush? __________________________

Do you like your smile ? □ Yes □ No

MEDICAL HISTORY

Physician's name ____Date of last visit __________________________

Physician's Phone Number ____Blood Pressure____________________________

□ Yes □ No Have you had any serious illnesses or operations? If yes, please describe ________________________________

□ Yes □ No Have you ever had a blood transfusion? If yes, give approximate dates ____________________________________

□ Yes □ No Have you ever had trouble from previous dental care? If Yes, please explain ______________________________

□ Yes □ No Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates?

□ Yes □ No Have you ever taken Fen-Phen/Redux?

□ Yes □ No Do you use controlled substances?

WOMEN: Are you pregnant? □ Yes □ No Due date __________ Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Please check if you have/had:

- □ Allergies, hay fever, sinusitis
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial heart valves
- □ Artificial joints
- □ Asthma
- □ Bleeding abnormally (operation or surgery)
- □ Blood disease, clotting disorders
- □ Cancer
- □ Chemical dependency
- □ Chemotherapy
- □ Circulatory problems
- □ Cough, persistent or bloody
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Fainting
- □ Headaches
- □ Heart attack
- □ Heart murmur
- □ Heart problems
- □ Hepatitis type__________
- □ Herpes
- □ High blood pressure
- □ HIV / AIDS
- □ Any immune deficiency
- □ Jaundice
- □ Low blood pressure
- □ Mitral valve prolapse
- □ Osteoporosis
- □ Any other health conditions not listed: ______________________________
- □ Osteopenia
- □ Pacemaker
- □ Radiation treatments
- □ Respiratory disease
- □ Shortness of breath
- □ Sinus trouble
- □ Sickle Cell Anemia
- □ Slow healing wounds
- □ Stroke
- □ Swelling of feet or ankles
- □ Thyroid problems
- □ Tuberculosis
- □ Tumor or growth on head/neck
- □ Weight loss, unexplained
- □ Do you wear contact lenses?

Are you allergic to or have you had any reactions to the following?

- □ Local Anesthetics (i.e. Novocaine)
- □ Penicillin or any other antibiotics
- □ Sulfa drugs
- □ Other Allergies:____
- □ Aspirin
- □ Sedatives
- □ Iodine
- □ Latex Rubber
- □ Metals (i.e. nickel, mercury, etc.)
- □ Barbiturates

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I attest to the accuracy of the information on this page.

Signature of Patient ____ Date ________________

(Patient or Parent/Guardian if minor)

CURRENT MEDICATIONS

Patient Name: ____ Date:__________________

Are you taking any medications, vitamins or supplements? ☐ Yes ☐ No

If yes, please list below:

Medication Name	Reason

Do you need to pre-medicate with antibiotics prior to dental treatment? ☐ Yes ☐ No
If yes, which antibiotic? ___________________________

UPDATES: Within the past year, have you been diagnosed with any new conditions or undergone any surgical procedures? Have you added or eliminated ANY medication within the last year? ☐ Yes ☐ No

If yes, please list Medication/Reason below: ____

____

Patient Signature:____ Date:_________________________

PATIENT NAME: ____ DATE:____________________

FINANCIAL POLICY

We welcome you to our practice! Friedman Dental Group is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please let us know if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORMS" BEFORE SEEING THE DENTAL PROFESSIONAL
- FULL PAYMENT IS DUE AT THE TIME OF SERVICE
- FRIEDMAN DENTAL GROUP PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS.
- PATIENTS ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THEIR INSURANCE, FOR ALL SERVICES RENDERED ON THEIR BEHALF OR DEPENDENT'S BEHALF.
- FOR YOUR CONVENIENCE WE OFFER THE FOLLOWING METHODS OF PAYMENT.
- PLEASE CHECK THE OPTION YOU PREFER:

  ☐ CASH ☐ CREDIT CARD (Visa, MC, Amex, Disc) ☐ WISH TO DISCUSS FINANCING OPTIONS

MISSED APPOINTMENTS/CANCELLATION POLICY

Our Doctors and staff have made a promise to professionally and personally give you the care, concern and respect that makes our office a comfortable and caring place to visit. Therefore, we require the courtesy of a 48-hour notice of cancellation of all scheduled appointments (excluding weekends). You deserve our undivided attention and for this reason, we do not double-book our schedule like other practices. Our office policy is that if we do not receive a 48-hour notification of cancellation on your appointment, there will be a charge of $50.00 for your hygiene/regular appointment, a $250.00 charge for appointments scheduled for 2 hours, and a $750.00 for any appointments scheduled for 3 hours or longer. Please help us service you better by keeping scheduled appointments.

Thank you for understanding our "Financial and Cancellation Policies." Please let us know if you have any questions.

I HAVE READ AND UNDERSTAND THE FINAINCIAL AND CANCELLATION POLICY OF THE OFFICE.

Print Name: ____

Patient Signature: ____ Date: _________________________

PROSTHODONTICS, IMPLANT & COSMETIC DENTISTRY
www.friedmandentalgroup.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? □ YES □ NO

May we leave a message on your answering machine at home or on your cell phone? □ YES □ NO

May we discuss your medical condition with any member of your family? □ YES □ NO

If YES, please name the members allowed: ____

This consent was signed by:

Print Name: ____

Signature:____ Date: ______________

PROSTHODONTICS, IMPLANT & COSMETIC DENTISTRY
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Photographs & Videos

I, ___________________________________ (Patient), hereby authorize Friedman Dental Group and any and all employees and/or agents of Friedman Dental Group the right and permission, to use and/or publish photographs and/or videos of my face, jaws and teeth, before, during and after treatment. These photographs and/or videos may be used for art, promotional and educational purposes (including but not limited to advertising, publicity, commercial or display of use).

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I hereby release and discharge Friedman Dental Group and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

____ **YES**, you may use my photos & videos.
____ **NO**, please do not use my photos & videos.

_____Check here if you DO NOT want your full face shot used for any of the above purposes

Patient's Signature: ____ **Date**:________________

Witness Signature: ____ **Date**:________________