**BURTON DENTAL PATIENT INFORMATION** **DATE**_____

**PATIENT** NAME_____PREFERRED FIRST NAME_____

STREET ADDRESS_____CITY, STATE, ZIP_____

MAILING ADDRESS_____CITY, STATE, ZIP_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

BIRTHDATE_____SS#_____DL#_____EMAIL_____

*soc sec # and drivers license # required if we are filing insurance for you and/or if account is not paid in full at each appointment

EMPLOYER_____FULL TIME STUDENT? WHERE?_____

MALE_____FEMALE_____ SINGLE_____MARRIED_____DIVORCED_____SEPARATED_____WIDOWED_____

**RESPONSIBLE PARTY AND/OR INSURANCE HOLDER** NAME (if different than patient)_____

STREET ADDRESS_____CITY, STATE, ZIP_____

MAILING ADDRESS_____CITY, STATE, ZIP_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

BIRTHDATE_____SS#_____DL#_____EMAIL_____

*soc sec # and drivers license # required if we are filing insurance for you and/or if account is not paid in full at each appointment

EMPLOYER_____RELATIONSHIP TO PATIENT_____

**INSURANCE COMPANY**_____ID #_____GROUP #_____

INSURANCE ADDRESS_____PHONE #_____

EFFECTIVE DATE_____

If the dental insurance policy is through someone other than the patient or responsible party, or if you have more than one coverage please ask for an additional form

If you have dental insurance, we are happy to process your claims for you. Your estimated insurance co-pay/co-insurance is due the day of the appointment unless other arrangements are made. **I understand that my dental insurance is a contract between the insurance company and myself, not between the insurance company and the dentist. I have read my policy and understand my dental coverage. I understand that my dental insurance policy may not cover all fees according to the estimate provided by Burton Dental. I understand I am responsible to pay all fees not covered by my insurance.** I, hereby, authorize my dental insurance company to make payment directly to Burton Dental. I grant the right to Burton Dental to release dental and medical histories and other information about dental treatment to third party payers (the insurance). I understand that I will be charged for all dental treatment. Any payments received from my insurance coverage will be credited to my dental account or refunded to me if such payment results in a credit balance on the account._____

**I understand** that I am responsible for all costs of dental treatment for all persons placed on my account. The balance for dental services is due the day of the appointment unless other arrangements are made. I understand that a fee of $25 per half hour scheduled may be charged for any appointment broken without 24 hours notice**. I understand that a 1.75% monthly (21% APR) finance charge ($2 minimum) may be charged on all account balances over 60 days past due.** I agree to pay cost and attorney's fees if any delinquent balance is placed with an agency or attorney for collection of suit (up to 40% of the balance that is turned over)._____

**I acknowledge** that I have received or have been offered a copy of the Burton Dental notice of privacy practices. The information that may be disclosed is outlined in the privacy act notice. If I am listed on an account other than my own (spouse, parents, legal guardian) and/or am covered by an insurance policy in any other name but my own, I authorize release of this information to the account holder and/or insurance policy holder. Also, information may be disclosed to a spouse, parent, and/or adult child.

SIGNATURE_____DATE_____

(Patient, legal guardian or authorized agent of patient)

**MEDICAL QUESTIONNAIRE** **PATIENT NAME: _____**

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.

EMERGENCY CONTACT_____PHONE #_____

Are you under a physician's care now? _____ If yes, Doctor's name and treatment_____

Have you ever been hospitalized or had a major operation? _____If yes, please explain_____

Have you ever had a serious head or neck injury? _____If yes, please explain_____

Are you taking any medications (Rx or over the counter)?_____If yes, please list_____

Do you take, or have you taken Phen-Fen or Redux? _____If yes, have you had your heart checked?_____

Have you ever taken medications containing bisphosphonate/Fosamax,Boniva,Actonel?_____

Are you on a special diet?_____ Do you use tobacco?_____ Do you use controlled substances?_____ Are you pregnant/trying to get pregnant?_____

Are you allergic to any of the following? Aspirin _____Penicillin_____ Codeine_____ Acrylic_____ Metal_____ Latex_____ _Local Anesthetics_____

List any other allergies including foods_____

Do you have, or have you had any of the following? Please circle.

| | | | |
|---|---|---|---|
| AIDS/HIV positive | Cortisone Medicine | Hemophilia | Renal Dialysis |
| Alzheimer's | Diabetes | Hepatitis A | Rheumatic Fever |
| Anaphylaxis | Drug Addiction | Hepatitis B or C | Rheumatism |
| Anemia | Easily Winded | Herpes | Scarlet Fever |
| Angina | Emphysema | High Blood Pressure | Shingles |
| Arthritis/Gout | Epilepsy or Seizures | Hives or Rash | Sickle Cell Disease |
| Artificial Heart Valve | Excessive Bleeding | Hypoglycemia | Sinus Trouble |
| Artificial Joint | Excessive Thirst | Irregular Heartbeat | Spina Bifida |
| Asthma | Fainting Spells/Dizziness | Kidney Problems | Stomach/Intestinal Disease |
| Blood Disease | Frequent Cough | Leukemia | Stroke |
| Blood Transfusion | Frequent Diarrhea | Liver Disease | Swelling of Limbs |
| Breathing Problem | Frequent Headaches | Low Blood Pressure | Thyroid Disease |
| Bruise Easily | Genital Herpes | Lung Disease | Tonsillitis |
| Cancer | Glaucoma | Mitral Valve Prolapse | Tuberculosis |
| Chemotherapy | Hay Fever | Pain in Jaw Joints | Tumors or Growths |
| Chest Pains | Heart Attack/Failure | Parathyroid Disease | Ulcers |
| Cold Sores/Fever Blisters | Heart Murmur | Psychiatric Care | Venereal Disease |
| Congenital Heart Disorder | Heart Pace Maker | Radiation Treatments | Yellow Jaundice |
| Convulsions | Heart Trouble/Disease | Recent Weight Loss | Osteoporosis |

Have you ever had any serious illness not listed above? _____If yes, please explain_____

**HAVE YOU EVER BEEN TOLD TO TAKE ANTI-BIOTICS (PRE-MEDICATE) BEFORE A DENTAL APPOINTMENT? _____**If yes, explain_____

**I certify** that the answers to the health questions on this page are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify this dental practice of any changes at any subsequent appointment.

**I authorize** treating dentist to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents(s), including those related to restorative, palliative, therapeutic or surgical treatments.

**I understand** that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. Occasionally, drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

**I understand** that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

**I understand** that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and a\may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

**I understand** the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of no-healing of the jawbones following oral surgery or tooth extractions.

**I do voluntarily assume** any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. _____

SIGNATURE_____DATE_____

(Patient, legal guardian or authorized agent of patient)