Urgent Dental Care of Somersworth, PLLC DBA Urgent Dental Care of New Hampshire at Somersworth
&
C.J. Auty, DDS, Oral Surgery, PLLC

Today's Date_____

PATIENT INFORMATION:

First Name _____ M.I._____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

E-mail_____ P.O. Box _____

Street_____ Apt. _____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ _____ Has a family member ever been a patient of our practice? ❑ Yes ❑ No
FIRST NAME LAST NAME

Dentist_____ _____ Orthodontist_____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Medical Dr._____ _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel.(_____)_____ Ext._____

Student: ❑ Full Time ❑ Part Time ❑ Not School Name _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ _____ Birth Date _____
FIRST NAME LAST NAME

Tel.(_____)_____ Cell. (_____)_____ E-mail _____

Street _____ Apt. _____ City_____ State_____ Zip _____

Employer_____ Bus. Tel.(_____) _____

The parent / guardian accompanying the patient on the day of service will be considered the financially responsible party.

PRIMARY DENTAL INSURANCE COMPANY:

Insurance Co. Name _____

ID # _____

Group # _____

Insurance Address _____

City_____ State _____ Zip _____

Telephone (_____)_____

Policy Holder _____

Policy Holder's Address _____

City _____ State _____ Zip_____

Relation _____ Birth Date_____

Policy Holder's Employer _____

PRIMARY MEDICAL INSURANCE COMPANY:

Insurance Co. Name _____

ID # _____

Group # _____

Insurance Address _____

City_____ State _____ Zip _____

Telephone (_____)_____

Policy Holder _____

Policy Holder's Address _____

City _____ State _____ Zip_____

Relation _____ Birth Date_____

Policy Holder's Employer _____

SECONDARY DENTAL INSURANCE COMPANY:

Insurance Co. Name _____

ID # _____

Group # _____

Insurance Address _____

City_____ State _____ Zip _____

Telephone (_____)_____

Policy Holder _____

Policy Holder's Address _____

City _____ State _____ Zip_____

Relation _____ Birth Date_____

Policy Holder's Employer _____

SECONDARY MEDICAL INSURANCE COMPANY:

Insurance Co. Name _____

ID # _____

Group # _____

Insurance Address _____

City_____ State _____ Zip _____

Telephone (_____)_____

Policy Holder _____

Policy Holder's Address _____

City _____ State _____ Zip_____

Relation _____ Birth Date_____

Policy Holder's Employer _____

HEALTH HISTORY:

Patient's Name _____

To our patients: *Although dentists and oral surgeons 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 medications that you may be taking, could have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke? If so, number of packs a day _____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Chronic Pain / pain management?			
49. Stomach ulcers / acid reflux?			
50. Contagious diseases?			
51. Sexually transmitted diseases?			
52. HIV / AIDS?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of drug abuse?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 66–69)*

		Yes	No
66.	Is there a possibility of pregnancy?	❑	❑
67.	Expected delivery date? _____		
68.	Are you nursing?	❑	❑
69.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

Patient's Name _____

ARE YOU NOW TAKING:	YES	NO	NOTES
70. Any kind of medication, drug, pills?			
71. Blood thinners (Coumadin, Plavix, Aspirin, Aggrenox, Pradaxa, Eliquis, Xarelto, other)?			
72. Any natural product, herbal supplement or homeopathic remedy (Ginko Biloba, Fish oil, Ginseng)?			
73. Steroids?			
74. Recreational drugs (Marijuana, other)?			
75. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?			
76. Have you ever taken diet pills?			

77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

78. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
79. Do you have any known allergies?			
80. Local anesthetic (numbing meds.)?			
81. Amoxicillin / Penicillin?			
82. Sulfa drugs?			
83. Other antibiotics?			
84. Sodium pentothal / Valium /other tranquilizers?			
85. Aspirin?			
86. Codeine or other narcotics?			
87. Latex?			
88. Soy?			
89. Eggs / yolk?			
90. Sulfites?			

91. Please list any allergies other than drug allergies:

92. Please list any other medication or antibiotic you are allergic to:

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Brief description of accident _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

MEDICAL UPDATE

I have read my medical history dated ____ / ____ / ____ and confirm that it adequately states past and present conditions.

Exceptions _____

X _____ **X** _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Doctor's Initials** **Date**

Patient's Name _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Doctor's Initials** **Date**

FEES & PAYMENTS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees, and court costs.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **X** _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I hereby acknowledge that this authorization shall be equally valid for myself or as a guardian for my child. I hereby authorize Urgent Dental Care of Somersworth, PPLC and C.J. Auty, DDS, Oral Surgery, PLLC to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to other doctors and/or insurance carriers. I consent to any advisable, necessary dental procedures, including the administering of any medications or anesthetics necessary to complete my dental treatment.

I understand Urgent Dental Care of Somersworth, PPLC and C.J. Auty, DDS, Oral Surgery, PPLC are independent legal entities but do work collaboratively for the benefit and convenience of the patients treated at the facility and therefore may share resources, billing systems and patient information for a seamless treatment experience. I understand that my care may be referred between the two entities or other dental specialists and affiliated practices when necessary. I understand and consent to the fact that my private information may be shared between Urgent Dental Care of Somersworth, PLLC and other Urgent Dental Care of New Hampshire affiliates as well as C.J. Auty, DDS, Oral Surgery, PLLC and at all times this personal information will be protected using HIPAA guidelines.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not limited to: * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly including any other dentists or specialist to whom we are referring you to for treatment or evaluation. * Obtain payment from third-party payers. * Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have either received your full length Notice of Privacy Practices or understand that I may request a copy of it at any time which resides on our office website www.urgentdentalcareofnh.com. The full length agreement contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand (and Consent by signing this form) that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I am being advised that I may receive phone, email or text messages about my appointments as well as messages left on answering machine or voicemail and I must request in writing if I do not wish to receive such communications.

Additional Person's to Whom we may speak regarding your dental treatment/account. You may revoke this permission at any time in writing:

_____

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**