PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Bisphosphonates
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Congenital Heart Defect
☐ ☐	Damaged Heart Valve
☐ ☐	Dental Anxiety
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Emphysema
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Hay Fever

Y N	Conditions
☐ ☐	Heart Attack
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Heart Trouble
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	High Blood Pressure
☐ ☐	Immunosuppressive Disorders
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Prosthetic Joint Replacement
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Recreational Drug Use
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sinus Problems
☐ ☐	Stroke

Y N	Conditions
☐ ☐	Thyroid Problems
☐ ☐	Transplanted Organs
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

WEST END
DENTAL GROUP

General Consent Form

Patient name: _____

Please read this form before you sign it.

Medical History Information

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

Restorations

I understand that care must be exercised in chewing on fillings until directed by doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, for example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary after consultation.

Complications

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth (which in transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.

Antibiotics

Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

Nitrous Oxide

The use of Nitrous Oxide has been fully explained to me, including the risks involved. I have been fully informed that temporary complications may include, but are not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue, head or cheek area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonation in the voice or presence of a hypernasal tone; warm feeling throughout body, with flushed cheeks, fits of uncontrollable laughter or giddiness detachment or disassociation from environment may occur; intense and uncomfortable warm and/or hot feeling throughout body; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucinations. All of these complications are temporary. I accept and understand that I must notify the doctor if: (1) I am pregnant, (2) I have sensitivity to any medication, (3) I have recently consumed alcohol, and/or (4) I am presently on psychiatric mood altering drugs or other medications.

WEST END
DENTAL GROUP

X-rays and photos

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentist with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients will receive necessary x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. At times during the course of treatment, x-rays and intraoral photos are required for insurance payment. We will not release these photos to anyone other than your insurance carrier without your permission.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Minors

We must receive **written** consent **prior** to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given **written** consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day.

Requests for records/xrays

By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will **NOT** be released. The patient or a designated person may request copies of their x-rays or record, however, there is a fee for duplication. We also require a minimum of 5 days notice to copy x-rays. There is no fee for us to send x-rays to a specialist that we refer you to.

Specialty Referral and/or Second Opinion

General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist.

I hereby authorize the dental staff of West End Dental Group, PLLC to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions. I consent to allow West End Dental Group, PLLC to take x-rays and perform an examination on me today.

Patient or Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

West End Dental Group

Truth in Lending Agreement

We are 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 us. Please ask if you have any questions about our fees, our Financial Policy, or your responsibility.

- **Full payment is due at time of service unless prior arrangements have been made.**
- **We accept cash, check, and major credit cards.**
- **Outside finance options are available.**

We file insurance claims as a courtesy for our patients and will do everything to maximize your benefits. I hear by agree to assign all insurance payments to West End Dental Group, Dr Michael Olson, and his associates. I am aware that there is no guarantee that insurance will cover all of the professional fees and the patient portion is only an estimate. I agree to pay, within 30 days, any outstanding balance following payment or denial by my insurance company.

In the event a check is returned from a financial institution a return check fee of **$35.00** will be applied. This office does assess an 18% annual percentage rate on all balances past 60 days until the account is paid in full.
In the event of default, I promise to pay legal interest on the indebtedness together with such collection cost as may be required to effect the collection of this agreement.

Effective January 1, 2015, there will be a $26.00 fee for missed and cancelled appointments without a 48 hour notice.

Date:_____ Signature:_____

Witness:_____

West End Dental Group, PLLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgment.

I, _____, have received a copy of this offices's Notice of Privacy Practices.
(Patient or Parent's Name)

_____
Patient or Parent's Name

_____
Signature

_____
Date

_____
Patient or Parent's Name

_____
Patient or Parent's Name

_____
Patient or Parent's Name

I authorize Dr. Michael Olson, and his staff to disclose my protected health care information with the following persons:

_____ _____ _____

_____ _____ _____
Patient's Signature

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)

_____

_____

ATIENT INFORMATION - MINOI

**Please Print

Date_____

Patients Legal Name_____ Preferred Name_____ M_____ F_____

Home Address_____ City/State/Zip_____

Mailing Address_____ City/State/Zip_____

Home Ph#_____ Cell #_____ email_____ Date of Birth_____/_____/_____

SSN_____ School_____ Grade_____

Person Responsible for Account_____ HomePh#_____ Cell #_____

Home Address_____ City/State/Zip_____

Mailing Address_____ City/State/Zip_____

SSN_____ Date of Birth_____/_____/_____ Employer_____ BusTel#_____

Person to contact in an emergency_____ Relationship_____

Home Ph#_____ Bus Ph#_____ Cell #_____ Address_____

ACCOUNT INFORMATION

Mother's Name_____

___Married ___Single ___Divorced ___Separated ___Widowed

Address_____

City/State/Zip_____

Home Ph#_____ Cell #_____

Date of Birth_____/_____/_____ SSN_____

Employer_____

Bus.Ph#_____

Father's Name_____

__Married ___Single ___Divorced __Separated ___Widowed

Address_____

City/State/Zip_____

Home Ph#_____ Cell #_____

Date of Birth_____/_____/_____ SSN_____

Employer_____

Bus.Ph#_____

Is there step parent information? Yes_____ No_____ If so, please complete the following:

Name_____

Relationship to patient_____

Address_____

City/State/Zip_____

Employer_____

Bus.Ph#_____

Date of Birth_____/_____/_____ SSN_____

HmPh#_____ Cell#_____

IS THERE DENTAL INSURANCE THAT WE NEED TO CONSIDER?

Primary:

Insured_____ SSN:_____ ID#_____ DOB_____

Ins Co _____ Ph #_____ Group #_____

Secondary:

Insured_____ SSN:_____ ID#_____ DOB_____

Ins Co _____ Ph #_____ Group #_____

*Are you covered by a third policy?*_____

GETTING TO KNOW YOU

Is another member of your family a patient in our office_____

Name_____ Relationship_____

PATIENT INFORMATION

****Please Print** Date_____

Patients Legal Name_____ Preferred Name_____ M_____ F_____

Home Address_____ City/State/Zip_____

Mailing Address_____ City/State/Zip_____

Home Ph# _____ Work Ph# _____ Cell #_____ email _____

SSN _____ DL#/State _____ Date of Birth _____ Marital Status S M D W

Your Occupation_____ Employer_____ Bus Tel#_____

Spouse's Name_____ SSN _____ Date of Birth _____

Spouse's Occupation_____ Employer_____ Bus Tel#_____

Person to contact in an emergency_____ Relationship_____

Res Tel#_____ Bus Tel #_____ Cell #_____ Address _____

Person responsible for account_____ Res Tel#_____ Bus Tel #_____

What is your chief complaint or concern?_____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary:

Insured_____ SSN:_____ ID#_____ DOB_____

Ins Co _____ Ph #_____ Group #_____

Secondary:

Insured_____ SSN:_____ ID#_____ DOB_____

Ins Co _____ Ph #_____ Group #_____

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL.

Previous Dentist_____ City_____ How Long_____

Date of last visit_____ Last cleaning_____ Last full series of xrays_____

1. Why did you leave your last dentist?_____
2. What did you like about any dentist or dental office you have been to?_____
3. What did you like the least?_____
4. Are you having any discomfort at this time? No_____ Yes_____, _____
5. Have you ever had any serious trouble associated with previous dental treatment? Yes_____ No_____
   If so, please explain_____
6. Does dental treatment make you nervous? Yes_____ No_____
7. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes_____ No_____

Check any of the following you have had or currently have:

_____ Gum Abscesses
_____ Gums bleed when brushing
_____ Grind or clench your teeth
_____ Pain, Clicking, Popping in jaw joints
_____ Orthodontic treatment
_____ Immediate relative that has lost all their natural teeth
_____ Mouth odor or bad taste
_____ Cold sores or fever blisters
_____ Loose or shifting teeth
_____ Sensitive teeth (hot, cold, sweets)
_____ Awake with sore jaws

If you could change one thing about your smile, what would that be?_____

_____