REMMERS
DENTAL

Today's Date:

Patient's Name		Preferred Name	
Birth Date			Sex M F
SS#	Single	Married	Child
Home Address		E-Mail	
City	State	Zip	
Home #	Cell #	Work#	
Employer		Full Time Student	Y N
If patient is a minor:	Mother's DOB	Father's DOB	

Person Responsible for Account (if other than patient)

Name		SS#
Home #	Cell#	Work#
Employer		

Emergency Contact Information (relative not living with you)

Name______________________________________ Relationship__________________

Address____________________________________ Phone_______________________

How did you hear about our office?

Location/Sign	Internet! Search Engine	Television	Event:	Promotion:
Patient/Friend/Family Member - Name:				
Other (please specify)				

Dental Insurance - Primary	Dental Insurance - Secondary
Insured's Name	Insured's Name
Insured's DOB	Insured's DOB
Insured's SS#	Insured's SS#
Ins. Co. Name	Ins. Co. Name
Ins. Co. Phone#	Ins. Co. Phone#
Group#	Group#
ID#	ID#

Dental History

Please check any of the following that apply to you:
- o Sensitivity (hot, cold, sweets, pressure)
- o Discomfort when chewing
- o Headaches, ear aches, neck pain
- o Jaw joint pain
- o Teeth with fillings breaking
- o Grinding or clenching teeth
- o Bleeding, swollen or irritated gums
- o Loose, chipped or shifting teeth
- o Bad breath or bad taste in your mouth

Do you have or have you ever had any of the following?
- o Dentures
- o Partial Dentures
- o Braces
- o Periodontal (gum) treatments

Have you ever had an evaluation at a sleep center? Yes No

Have you ever been prescribed treatment with a CPAP? Yes No

What is the most important thing about your visit today?

What would you like to do to improve your smile?
- o Whiten
- o Straighten
- o Close spaces
- o Replace silver fillings with tooth colored fillings
- o Repair Chipped teeth
- o Replace missing teeth
- o Replace old crowns that don't match other teeth

Name of previous dentist ________________________ _

City & State ____________________________________ _

Phone# ____ _

Why did you leave your previous dentist?

How long has it been since your last dental hygiene visit?

Less than 1yr 1-2yrs 3-5yrs over 5yrs

Medical History

			Allergies
o AIDS/HIV positive	o Anemia	o Arthritis	o Aspirin
o Artificial Joints	o Asthma	o Blood Disease	o Codeine
o Cancer	o Diabetes	o Dizziness	o Erythromycin
o Epilepsy	o Excessive Bleeding	o Fainting	o Latex
o Glaucoma	o Head Injuries	o Heart Disease	o Nitrous Oxide
o Heart Murmur/Mitral Valve Prolapse	o Hepatitis ABC	o High Blood Pressure	o Penicillin
o Jaundice	o Kidney Disease	o Liver Disease	o Percodan
o Mental Disorders	o Nervousness/Depression	o Pacemaker	o Seasonal
o Pregnant	o Radiation Treatment	o Respiratory Problems	o Sulfa Drugs
o Rheumatic Fever	o Stroke	o Sinus Problems	o Valium
o Other ____________	o Stomach Problems	o Tobacco User (currently)	o Other

What medications do you take? ____

Family Doctor ____________________________ Phone # ____________________

ACKNOWLEDGEMENT AND RELEASE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. It is your responsibility to know your dental benefits and limitations before and during the course of treatment.

Collections

In the event the balance becomes more than 90 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed.

Patient/Parent Signature ____ Date ______________________ _

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

You may Refuse to Sign This Acknowledgement

<u>For Office Use Only</u>

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

O Individual refused to sign

O Communications barriers prohibited obtaining the acknowledgement

O An emergency situation prevented us from obtaining acknowledgement

O Other {Please Specify:

REMMERS DENTAL GENERAL CONSENT TO DENTAL TREATMENT

I, ______________________ , consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand the following.**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment), oral surgery, endodontics(root canals), fixed and removable prosthodontics(crowns, bridges, and dentures), implant dentistry, restorative dentistry, sleep apnea therapy, Botox application, oral sedation, pediatric dentistry, and radiography. I acknowledge that Dr. Remmers and his associates will make every effort to explain the nature and purpose of proposed procedures and alternative options, but it is the patient's responsibility to ask questions and elect for treatment.
2. I authorize Dr. Remmers and/or such associates or assistants as he may designate 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 legal responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
3. I voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative 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 or ward. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I have the right to refuse any specific dental treatment, and voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with foregoing any diagnostic or treatment procedure.
5. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.
6. I am welcome to ask questions about any aspect of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/Guardian Signature ___________________________________ Date _______________

Witness____ Date________________

APPOINTMENT AGREEMENT FOR REMMERS DENTAL

We are honored you have selected us for your dental care, to ensure we deliver exceptional dental care we are 100% committed to providing quality service. We believe an important aspect of exceptional dental care is our patients' commitment as well. Therefore, we ask that you honor your reserved appointment as scheduled. Should you need to change your appointment for any reason, we ask that you give us a 48 hour notice.

Because missed appointments increase the cost of healthcare for everyone, after 3 missed appointments in which a **48 hour notice** has not been given, we ask that all your appointments are schedule the day of treatment,

I have read, understand and will honor the Remmers Dental Appointment Agreement.

Patient Signature ____Date_______________