



Tel: 913-381-2828
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ChaneyDentalPV.com

WELCOME!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: How did you hear about us?

Name (First, Middle, Last):

I prefer to be addressed as: Circle One: Male Female

Birthdate: Age: SS#:

Mailing Address:

City: State: Zip:

Email Address:

Cell Phone: Home Phone:

Work Phone:

Employer: Occupation:

Employer's Address:

City: State: Zip:

Circle One: Single Married

Spouse's Name: Spouse's DOB:

Spouse's Employer: Occupation:

Other Family Members Seen by Us:

DENTAL INSURANCE

Do you have dental insurance coverage? Yes No

If yes, please complete the following section & present your dental insurance card at the front desk during check-in:

Dental Insurance Group #:

Dental Insurance ID #:

If the policy holder is other than yourself, please fill out the following:

Policy Holder's Name:

Policy Holder's Address:

City: State: Zip:

Relationship to Policy Holder:

Policy Holder's Birthdate: SS#:

Policy Holder's Primary Phone #:

Policy Holder's Employer:

EMERGENCY CONTACT

(Please specify someone who does not live in your household)

Name: Relationship:

Primary Phone #:

DENTAL HISTORY

Why have you come to our office today? Are you in pain? Yes No If yes, for how long?

Previous Dentist: Date of Last Cleaning: Date of Last Dental X-rays:

Have you ever been told that you require antibiotics prior to treatment? Yes No Do you like the way your smile looks? Yes No

If no, what do you dislike?

Do you have any old filling or other dental work that you are unhappy with? Yes No Have you ever wanted your teeth to be straighter? Yes No

Have you ever been diagnosed with or had concerns with Sleep Apnea? Yes No Are you anxious about receiving dental treatment? Yes No

If yes, what are your biggest concerns?

Please circle if you are currently having or have ever had problems with any of the following:

- Sensitivity to Cold - Bad Breath/Bad Taste - Sleep Apnea/Snoring - Periodontal Treatment
- Sensitivity to Hot - Bleeding/Painful Gums - Teeth Grinding/Clenching - Orthodontic Treatment
- Sensitivity to Sweets - Receding Gums - Jaw or Ear Pain - Loose or Broken Teeth
- Sensitivity Biting/Chewing - Food Collects Between Teeth - Jaw Clicking or Popping - Mouth Sores

Is there anything you would like to let us know (positive or negative) about your past dental experiences that may help us provide a better experience for you?

Blank lines for patient response to the final question.

PATIENT NAME _____ Birth Date _____

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.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please list: _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Penicillin Codeine Latex Sulfa Drugs Local Anesthetics Aspirin Acrylic Metal

Other If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments or details relevant to any of the above medical conditions: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

AUTHORIZATION AND RELEASE

Thank you for choosing Chaney Dental for your dental care. We are excited to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should also be aware that dental treatment, like treatment of any other part of the body, does come with inherent risks. Rarely do these risks offset the benefits of treatment, but they should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include, but are not limited to:

- Allergic reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Short-term and/or long-term numbness. Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness or altered sensation.
- Muscle or joint tenderness: Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection, or bleeding.
- Swallowing or inhaling small objects.

We follow strict procedural guidelines and protocols that most often lead to clinical success. However, dentistry is not an exact science and certain things cannot always be accounted for or guaranteed. We will do our best to ensure that it does. We encourage you to ask questions regarding all dental procedures that are recommended to you for yourself and/or your dependent(s).

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 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.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your Notice of Privacy Practices containing 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____ Relationship to patient: _____

Signature: _____ Date: _____