CHANEY DENTAL

Tel: 913-381-2828
Fax: 913-381-0428
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 Name: _____

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

_____

_____

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## MEDICAL HISTORY

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

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## 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 or 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 disclosers 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: _____