CLEAR CREEK DENTISTRY

New Patient Information

Date _____

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ SS#. _____

Email Address: _____ Best time to Call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext.) _____ (Mobile) _____ (Fax) _____ (Other)

**Please circle preferred contact number.*

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Employer

_____

Occupation

_____

Whom may we thank for referring you to our practice.

_____

Previous Dentist - Name and Phone Number

_____

May we contact your previous Dentist for dental records?

☐ Yes ☐ No

CLEAR CREEK DENTISTRY

Patient Dental History

Name _____ Date _____

1. What is your present dental concern? _____ Services Desired _____

2. Please describe your general dental health? _____

3. How long since your last dental visit? _____ Former Dentist _____

4. How long since your last dental cleaning visit? _____

5. Do you think you have active decay or gum disease? Y N

6. Are you worried about receiving dental treatment? Y N

7. Have you ever had an unusual reaction or problem with dental anesthetic or treatment? Y N

8. How often do you brush? _____ Brush Type: Soft Medium Hard

9. Do you use fluoride toothpaste? Y N

10. How often do you floss? _____ What other oral homecare products do you use? _____

_____

11. Is there anything you would change about the appearance of your teeth? Y N

12. Are you missing any teeth? Y N

13. Have they been replaced by bridges, partials, dentures or implants? Y N

14. Do your gums bleed when brushing or flossing? Y N

15. Does food pack between any teeth? Y N

16. Are any teeth sensitive to hot, cold, sweets, or pressure? Y N

17. Do you have a regular high sugar consumption habit (pop, hard candy, mints etc.)? Y N

18. Do you chew gum or hard objects such as ice, popcorn kernels, etc? Y N

19. Do you ever have popping, clicking, or discomfort in your jaw joint (TMJ)? Y N

20. Are you aware of clenching or grinding your teeth during the day or night? Y N

21. Do you have frequent headaches? Y N

22. Do you or have you ever worn a night guard? Y N

23. Do you have or have you had any slow healing sores or growths in your mouth? Y N

24. Circle any of the following concerns you have about your mouth, teeth and gums:

Bad Breath	Spaces	Periodontitis	Discolored Fillings
Bad Taste	Infection	Loose Teeth	Smile
Broken Teeth	Swollen Gums	Shifting Teeth	Gag easily
Missing Teeth	Red Gums	Appearance	Crooked Teeth
Old Fillings	Bleeding Gums	Bad Bite	Other:
Broken Fillings	Gingivitis	Dark Teeth	_____

25. How important is it to you to keep your existing natural teeth the rest of your life? _____

CHILDREN TO AGE 14 YEARS –

26. Is your current drinking water fluoridated? Y N

27. Is your child taking supplemental fluoride tablets/drops? Y N

28. Have your child's permanent molars been sealed? Y N

29. Does your child have any oral habits such as thumb sucking, lip biting, or mouth breathing etc.? Y N

CLEAR CREEK DENTISTRY

Patient Medical Information

Name _____ Date of Birth _____

Emergency Contact _____ Phone _____

Height _____ Weight _____ Physician's Name _____ Phone _____

1. Are you currently under medical care? Why? Y N

_____

2. Have you been hospitalized for any surgical operation or serious illness within the past 5 years? Y N

3. Are you limited in activity because of a physical or medical condition? Y N

4. Please list any medications you are taking. _____

_____

_____

5. Please list any allergies to medications, latex, or metals. _____

_____

6. Have you ever had any serious trouble associated with previous dental treatment or dental anesthetic? Y N

7. Do you use tobacco? *If yes, please list type and history.* Y N

_____

8. Do you use controlled substances? *If yes, please list type and history.* Y N

_____

9. Have you experienced or do you have any of the following medical conditions:

1. Aids/HIV +
2. Anemia
3. Artificial Heart Valve
4. Arthritis
5. Artificial Joints
6. Asthma
7. Back Problems
8. Cancer
9. Chemical Dependency
10. Chemotherapy
11. Chest Pain
12. Circulatory Problems
13. Congenital Heart Lesions
14. Cortisone Treatments
15. Diabetes
16. Diet/Weight Loss
17. Epilepsy/Seizure
18. Fainting/Dizziness
19. Glaucoma
20. Headaches
21. Heart Attack
22. Heart Problems
23. Hepatitis
24. Herpes
25. High Blood Pressure
26. Kidney Disease
27. Liver Disease
28. Lung Disease
29. Nervous Disorder
30. Osteoporosis
31. Antibiotic Premedication
32. Prolonged Bleeding
33. Psychiatric Care
34. Radiation Treatment
35. Sinus Trouble
36. Stroke
37. Swollen Glands
38. Thyroid Problems
39. Tumors or Growths
40. Ulcers/Acid Reflux
41. Sleep Apnea

_____

_____

10. Do you have any other health problems that need further clarification? Y N

WOMEN ONLY –

11. Are you pregnant or think you may be pregnant? Y N **12.** Are you nursing? Y N

13. Are you taking oral contraceptives? Y N

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature _____ Date _____

OFFICE USE ONLY

MEDICAL UPDATES

Date *Changes*

BP _____ **P** _____

_____

_____

_____

CLEAR CREEK DENTISTRY

Consent for Services

Name _____ Date _____

As a condition of treatment by this office, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients with dental insurance understand that all dental services are subject to the dental insurance contract established between their employer and their insurance company, and that he or she is personally responsible for payment of all dental services. As a service to you, we will complete and file your insurance claim forms and assist in making collections from insurance companies. Insurance collections will be credited to the patient's account. The patient estimated portion of payment is expected at the time of treatment. A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

AUTHORIZATION TO RELEASE INFORMATION

Clear Creek Dentistry is hereby authorized to release any medical or incidental information that may be necessary for medical care, or in the processing of my dental insurance.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and Clear Creek Dentistry's duties with respect to my protected health information.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize disclosure of my protected health care information to the person indicated below.

- ☐ Any member of my immediate family
- ☐ Spouse only

I acknowledge that I have read the above statements and conditions and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____