THE PEARL
DENTISTRY
FAMILY • COSMETIC • IMPLANT DENTISTRY

Confidential Dental & Medical History

Patient Registration

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ ZIP code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

E-mail: _____ Best Contact: ❑EMAIL ❑CELL ❑TEXT ❑HOME

SS#_____ Employer/Occupation: _____

Marital Status: ❑SINGLE ❑MARRIED ❑WIDOWED ❑DIVORCED

How did you hear about us? _____

Emergency Contact

Spouse Name: _____ Spouse Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Phone: _____ Address: _____

Dental Insurance

Do you have dental insurance? ❑YES ❑NO

Insurance Carrier Name: _____

Is your insurance provided by an employer? ❑YES ❑NO

If yes, please list employer name: _____

Group/Plan Name: _____ Group#: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Date of Birth: _____ Relationship to Patient: ❑SPOUSE ❑CHILD

Note: The subscriber's social security number may be used in place of the subscriber/member ID number. The insurance carrier, ID/SSN, and DOB of the subscriber are required to verify benefits and submit claims. If you are unable to provide those details before your initial appointment, we will require you to pay in full at the time of service.

Medical History

In order for us to provide you with the safest and best possible care, please carefully read and complete the Medical History & Dental History forms. All information is kept strictly confidential.

Preferred pharmacy name: _____
Have you taken any prescription drugs in the last 6 months? ❑YES ❑NO
If yes, please list: _____
Are you taking any over the counter medications or herbal supplements? ❑YES ❑NO
If yes, please list: _____
Have you had surgery or been hospitalized? ❑YES ❑NO
If yes, please describe: _____
Are you allergic to penicillin? ❑YES ❑NO
Are you allergic to any other medications? ❑YES ❑NO
If yes, please list: _____
Have you ever had any excessive bleeding requiring special treatment? ❑YES ❑NO
Have you ever taken medication either by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? ❑YES ❑NO
If yes, please list: _____
Do you take antibiotics before you go to the dentist? ❑YES ❑NO
Do you drink alcohol? ❑YES ❑NO If yes, how frequently? ❑DAILY ❑WEEKLY ❑MONTHLY
Do you use tobacco? ❑YES ❑NO If yes, please describe: _____

Please indicate if you have or have had any of the following conditions:

❑ Low Blood Pressure	❑ Acid Reflux	❑ Chemotherapy
❑ High Blood Pressure	❑ Ulcers	❑ Radiation Treatment
❑ Heart Disease/Attack	❑ Liver Failure	❑ HIV/AIDS
❑ Angina Pectoris	❑ Hepatitis/Jaundice	❑ Anemia
❑ Artificial Heart Valve	❑ Diabetes	❑ Leukemia
❑ Heart Failure	❑ Thyroid Problems	❑ Bruise/Bleed Easily
❑ Heart Pacemaker	❑ Seizures/Epilepsy	❑ Osteoporosis
❑ Stroke	❑ Allergies/Sinus Problems	❑ Arthritis
❑ Kidney Problems	❑ Asthma/Bronchitis	❑ Joint Replacements
❑ Sexually Transmitted Disease	❑ Emphysema/COPD	❑ Sleep Apnea

Are you pregnant now? ❑YES ❑NO	Practicing birth control? ❑YES ❑NO	Plan to become pregnant? ❑YES ❑NO

Please read the following carefully:

To the best of my knowledge, all the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above-named patient dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetics or pre-medications which may be deemed advisable.

_____ _____

Signature of Patient or Guardian *Date*

Dental History

Answers to these questions help us provide safe and effective dental care, personalized to your individual needs.

When was your last dental visit? _____
What was completed during your last visit? _____
When was the last time you had dental x-rays? _____
How often do you have examinations? _____
How often do you brush your teeth? _____
How often do you floss? _____
What other dental aids do you use? _____
Do you have any dental problems that you are currently aware of? ❑YES ❑NO
If yes, please describe: _____
Do you feel nervous about dental treatment? ❑YES ❑NO
If yes, please describe: _____
Are any of your teeth sensitive to the following? ❑HOT ❑COLD ❑SWEETS ❑BITING/CHEWING
Have you noticed mouth odors or bad taste? ❑YES ❑NO
Do you frequently get cold sores? ❑YES ❑NO
Do you frequently get oral ulcers? ❑YES ❑NO
Do your gums bleed or hurt? ❑YES ❑NO
Have you noticed any loose teeth? ❑YES ❑NO
Have your teeth shifted over the years? ❑YES ❑NO
Does food tend to become caught between your teeth? ❑YES ❑NO

Please indicate if you have experienced any of the following:

❑ Clench or grind your teeth while awake or asleep
❑ Have tired jaws, especially in the morning
❑ Have a hard time opening wide
❑ Mouth-breathe while awake or asleep
❑ Hold foreign objects with your teeth (pencils, nails, etc.)
❑ Chew ice often
❑ Clicking or popping of the jaw
❑ Pain in the jaw joint near the ear
❑ Difficulty opening or closing the jaw
❑ Headaches, neck aches, or shoulder aches frequently
❑ Sore muscles in the neck or shoulders

Please indicate if you are interested in any of the following:

❑ Dental Implants	❑ Whitening	❑ Cosmetic Dentistry
❑ Veneers	❑ Bridges	❑ Other: _____
❑ Invisalign	❑ Dentures	

By signing below, I agree that all of the preceding information is true and correct, to the best of my knowledge.

_____ _____

Signature of Patient or Guardian *Date*

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our legal duty:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 06/27/23 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes to our privacy practice and the new terms of our Notice effective for all health information that we maintain. Including health information, we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and disclosures of health information:
We use and disclose health information for the purposes described below:
Treatment: We may use or disclose your health information to a physician or healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, digital photographs, or similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

_____

_____

_____

_____ _____

Signature of Patient or Guardian *Date*

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship:

_____

****

Office use only:

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because _____
❑ Other: _____

Cancellation Policy

Routine appointments require a **48-hour** advance notice to reschedule or cancel. Failure to provide advance notice will result in a charge of $50. This amount is not covered by insurance.

This allows us time to offer your reserved appointment to someone who is waiting for an appointment and may be in pain. We understand that there are things that happen in life, such as flat tires, illnesses, and unforeseen circumstances that may prevent you from keeping your appointment. If you let us know as soon as possible, we can help another patient with a dental emergency instead.

Thank you.

By signing below, I acknowledge that I have read and understand the procedures at The Pearl Dentistry regarding cancellations and rescheduling.

_____ _____

Signature of Patient or Guardian *Date*

Financial Arrangements

Payment is due at the time of service. Patients with insurance will be expected to pay their "Estimated Patient Portion" which is calculated based upon the information we receive from the insurance company. This estimated amount will be due on or before the day of service. Any balance due after the insurance has paid will become the responsibility of the patient and will be due within thirty (30) days of the statement date.

Payment options:

- Cash, cashier's check, personal check
- MasterCard, VISA, Discover, American Express
- Patient Financing – We work with several financial organizations (see below) that will allow you to get the treatment you need now and spread the payments over as much as 60 months (about 5 years), including programs with no interest.

CareCredit®
Making care possible...today.

LendingClub

Our mission is to help you achieve the best possible dental health. Our job is to evaluate the state of your oral health and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. Your job is to determine what treatment option is best for you, and the pace at which you wish to proceed with your treatment. We will gladly respect your decisions.

Office Policy Regarding Dental Insurance:
Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. Please carefully read the following statement and sign below.

I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to The Pearl Dentistry at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full at time of service, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____ _____

Signature of Patient or Guardian *Date*