Fabey Dental

Passion ~ Possibilities ~ Precision

Patient Information

(ALL areas that apply must be filled out & SIGNED)

Patient Name____ Date of Birth____________________

Address___________________________________ City __________________ State ______ Zip _________

Home Phone________________________________ Cell Phone______________________________

S.S. #_____________________________________ Driver's Lic# __________________________

Email Address______________________________

Employer__________________________________ Work # ____________________ext__________

Spouse Name: ______________________________________ Date of Birth_______________________

S.S. #____ Phone#___________________________

Parent/Guardian

Who is responsible for the patient? ______________________________ Relationship__________________

Whom may we thank for referring you to our office? ____

Physician Name____________________________________ PH#____________________________________

Previous Dentist____________________________________ PH#____________________________________

Primary Dental Insurance Co____________________________________ Group #_____________________

Name of Insured____ Date of Birth_________________

Insured's Soc. Sec/ID #______________________________

Medical Insurance Co________________________________ Group #__________________________

Permission is hereby granted to the Doctor to perform any **necessary** dental work. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the information above.

THE DENTIST HAS RESERVED VALUABLE TIME FOR YOUR APPOINTMENT. PLEASE HONOR YOUR SCHEDULED APPOINTMENTS AND ARRIVE ON TIME. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT *A 24 HR. NOTICE IS REQUIRED,* OTHERWISE A $25 FEE WILL BE CHARGED TO YOUR ACCOUNT.

XXX Signature ____ **Date**______________________

Medical Questionnaire

(Please fill out all that apply)

Patient Name_______________________________________

Please circle any condition you have a history of:

High Blood Pressure	Heart Trouble	Valve Replacement	Angina
Low Blood Pressure	Heart Murmur	Mitral Valve Prolapse	Asthma
Nervous Disorders	Hay Fever	Radiation Therapy	Leukemia
Diabetes	Rheumatic Fever	Tuberculosis	Kidney Disease
Joint replacement	Hepatitis	Bronchitis	Stroke
AIDS/HIV Positive	Cancer	Epilepsy	Organ Transplant
Thyroid	Herpes	Psychiatric Treatment	Sinus/seasonal allergies
Glaucoma	Arthritis	Venereal disease	Drug Dependency
Osteoporosis	Pacemaker	Blood Disease	Sleep Apnea

*** Are there any other conditions that may be important to your care? _____________________________________

****

Is the Patient under the care of a Physician at this time or within the last 2 years? ______ Yes ______ No

If so, for what ____

****

Have you been hospitalized/had major surgery in the last 2 years? ______ Yes ______ No

If so, for what? ____

****

Have you ever had an A**llergic Reaction** to any medications or materials? ______ Yes ______ No

If so, what medication/materials? ____

****

If female: Are you pregnant or nursing? ______ Yes ______ No

Are you taking birth control or hormones? ______ Yes ______ No

Have you ever been told that you need pre-medication before a dental appointment? ______ Yes ______ No

Are you currently taking any medications? ______ Yes ______ No If so, please list below:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Do you smoke? ______ Yes ______ No Do you chew tobacco? ______ Yes ______ No

Permission is hereby granted to perform any necessary dental work and authorize my insurance company to pay the dentist or dental group all insurance benefits. I also understand that (regardless of insurance status), I am responsible for the balance on this account for any and all services rendered to me or my dependents. I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health or the information above.

XXX Signature____ Parent or Guardian

Dental Questionnaire

How do you feel about the appearance of your smile? ______________________________

Are you interested in a complimentary simulated Smile Makeover Photo? Yes ____________No__

What would you improve about your smile? ______________________________________

Do your gums ever bleed? ______ Yes ______ No When? ___________________________

Are you aware that your gum health can easily place you at risk for a heart attack, stroke, the onset of diabetes, and pregnancy complications? ______ Yes ______ No

Does this info concern you? ______ Yes ______ No

Are you concerned about your health? ______ Yes ______ No Why? _________________________

Do you experience frequent headaches or migraines presently? ______ Yes ______ No

In the past? ______ Yes ______ No

If so, do you wake up with a headache in the morning? ______ Yes ______ No

Has a headache limited your activities for a day or more in the last three months? ______ Yes ______ No

Are you aware that you clench or grind your teeth? ______ Yes ______ No

If so, when? ______________________________

Do you ever experience tightness, soreness or discomfort in your cheek muscles? ______ Yes ______ No

Do you ever experience soreness or tightness above the shoulders? ______ Yes ______ No

Do you or your partner snore? ______ Yes ______ No

If so, who? _______________________________

Do you feel well rested in the morning? ______ Yes ______ No

Do you routinely feel sleepy during the day? ______ Yes ______ No

If tired, please explain ____

Fabey Dental

We ask that you please take a moment and write down your dental goals in order to share them with us. We want to serve you to the best of our abilities and understanding what your desires and wants are should be the starting point of our relationship together. We want to make sure our recommendations will always be congruent with your short and long term goals. Thank you in advance for taking the time to do this.

My Dental Goals

- ❖ ____
- ❖ ____
- ❖ ____
- ❖ ____
- ❖ ____

XXX Patient Signature: ___________________________________ Date:__________

Fabey Dental

HIPAA Privacy Authorization Form

(MUST BE FILLED OUT AND SIGNED)

If you would like some person other than yourself to have access to your medical records and information, and allow health care providers to release such information to that person, you must authorize the release of the information in writing. Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person other than yourself to have access to that information now, while you remain competent, you need to complete and sign a HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

Release Information to:

Doctors: ALL____________ Specific ____

Spouse: _________________ Phone #____

Parents/ Guardian: ______________ Phone #____

Child/Children: _________________ Phone #_______________________________________

Where we can leave messages:

Home#_________________________ Answering machine________ Person_______

Work#__________________________ YES____ NO___

Spouse #________________________ YES____NO___

Mobile#_________________________ YES___ NO___

XXX Signature____ Date_____________________

Fabey Dental

Standard of Care

(Must be read and signed)

The standards of care that is practiced here at Fabey Dental is to promote the knowledge, values, and behaviors that support and enhance your oral health with the ultimate goal of improving overall health.

As we are an ADA Provider we are compliant with the standard that they have provided. These standards can and will be modified based on emerging scientific evidence, ADA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

We know it is important to you that you are made aware of the Treatment that will be provided for you:

Oral Exams by the Doctor – (Cleaning appointments) 2x year or 1 x year minimum

Bitewing X-rays – once a year, maximum twice a year

Full Mouth Series – every 3-5 years

Medical History – every two years

Oral Cancer Exam – each visit

Periodontal probing exam – once per year, alternating with bitewing X-rays

Fluoride Treatment- as need based on your health as discussed with the Hygienist or Doctor

Standard of care will NOT be dictated by the insurance plans.

We ask that you realize that we don't work for an insurance company. Rather we work 100% for our patients. We know that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

XXX Patients Signature____ Date_________