Plumb Dental

Welcome, let's get to know you.

We would like to welcome you to Plumb Dental. The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely The better we communicate, the better we can care for you. If you have any questions at any time, please ask us. We are happy to help.

1. Tell Us About Yourself

Name_____
First Last MI

Prefer to be called:_____

Birth Date: _____/_____/_____ Single ☐ Married ☐

SS#_____ DL#_____

Mailing Address:_____

_____

Mobile #:_____ Other #:_____

Email Address:_____

Employer:_____

2. How did you hear about us?

Who may we thank for referring you?_____

_____

Is there anyone in your immediate family a current patient at our office? (to link the account for insurance purposes)

Name:_____

Preferred Pharmacy:_____

Location:_____

Previous Dentist:_____

Last visit:_____

3. Who Is Your Emergency Contact?

Name_____ Relationship_____

Mobile #_____

4. Who Is Your Primary Physician?

Name:_____

Phone #:_____

Have you been hospitalized in the last 5 years? Yes No

If yes, Reason:_____☐_____☐_____

NOTICE: There will be a $50 charge for broken appointments without 24 hour notice.

5. Who Will Be Responsible For The Account?

Name_____Relation:_____
First Last

Mobile #:_____ Other #:_____

Billing Address:_____

_____

Birth Date: _____/_____/_____ SS#_____

Employer:_____

*I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature:_____ Date:_____

6. Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Phone:_____

Member ID:_____

Group #:_____

Insured's Name:_____

Insured's Birthdate: _____/_____/_____

Relation:_____

SS#:_____-_____-_____

Insured's Employer:_____

7. Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Phone:_____

Member ID:_____

Group #:_____

Insured's Name:_____

Insured's Birthdate: _____/_____/_____

Relation:_____

SS#:_____-_____-_____

Insured's Employer:_____

I authorize the release of information relation to any insurance claim, to my insurance Company. I understand that I am responsible for all costs of my dental treatment. I Authorize payment directly to Plumb Dental Inc. of the group insurance benefits otherwise payable to me.

Signature:_____ Date:_____

Plumb Dental

Your Medical History

_____

Are you currently receiving care? ☐Yes ☐ No
If yes, nature of care_____
Are you taking any prescription/over the counter drugs?
☐ Yes ☐ No
Please list each one:
_____
_____

For the following questions please circle yes or no. Your answers are for our records only and will be confidential. Our team may ask additional questions concerning your health.

Are you taking any of the following meds?

Antacids	Yes	No
Barbiturates (Any)	Yes	No
Biaxin (Clarithomycin)	Yes	No
Cardizem, Calan or Isoptin	Yes	No
Diflucan or Sporonox	Yes	No
Dilantin or Tegretol	Yes	No
Pre-Medication before appt.	Yes	No
Serzone	Yes	No
St. John's Wort or Kava-Kava	Yes	No
Tagamet or Prilosec	Yes	No

Are you allergic to any of the following drugs?

Aspirin, Ibuprofen, or Tylenol (circle)	Yes	No
Codeine	Yes	No
Dental Anesthetics	Yes	No
Erythromycin	Yes	No
Latex or Metals (circle)	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Tetracycline	Yes	No
Other (please specify) Including valium or other sedatives	Yes	No

Tobacco, Alcohol, Drugs

Do you use tobacco? Smoke or Chew	Yes	No
How much per day? For how long?		
Do you want to quit?	Yes	No
Do you consume alcohol	Yes	No

For Women Only

Are you taking birth control	Yes	No
Are you pregnant? #Weeks____	Yes	No
Are you Nursing	Yes	No

Anemia or blood disorder Hemophilia/Abnormal bleeding from a cut?	Yes	No
Asthma	Yes	No
Arthritis	Yes	No
Artificial bones or joints (circle) When placed?	Yes	No
Artificial valves	Yes	No
Blood transfusion	Yes	No
Cancer or Tumor	Yes	No
Colitis	Yes	No
Congenital Heart Defect	Yes	No
Diabetes	Yes	No
Emphysema/Lung Illness	Yes	No
Epilepsy	Yes	No
Fainting or Dizzy Spells	Yes	No
Fever Blisters	Yes	No
Glaucoma	Yes	No
Do you consume grapefruit in any form?	Yes	No
Have you ever been treated with bisphosphonate drugs? (Fosamax, Aredia, Zometa, Actonel, Boniva) If so, when?	Yes Circle all that apply	No
Heart Murmur, attack, surgery	Yes	No
Heart Stent – when placed?	Yes	No
Hepatitis A,B or C (circle)	Yes	No
HIV/Aids	Yes	No
High blood pressure	Yes	No
Kidney Disease	Yes	No
Liver Disease/ Jaundice	Yes	No
Low blood pressure	Yes	No
Mitral Valve prolapse	Yes	No
Pacemaker	Yes	No
Previous Drug/Alcohol Abuse	Yes	No
Psychiatric Problems	Yes	No
Radiation or Chemotherapy	Yes	No
Respiratory problems/Illness	Yes	No
Rheumatic Fever	Yes	No
Seizures	Yes	No
Sinus Problems	Yes	No
Stroke	Yes	No
Tuberculosis (TB)	Yes	No
Ulcers	Yes	No
Unintentional weight loss or gain? Have you ever taken Fen-phen?	Yes	No
Venereal Disease	Yes	No
Other Conditions	Yes	No

For office use only
B/P:_____ Date_____

P:_____ Asst._____

Plumb Dental

Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected healthy information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payments from third party payer (e.g. my insurance company, financing companies, etc);
- The day to day healthcare operations of your practice;

I have also been informed of, and given the right to review and secure a copy of your notice of privacy practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day or _____, 20____

Print Patient Name: _____

Relationship to patient: _____

Signature: _____

Plumb Dental

Attention: Important insurance information please read fully and carefully

In order to prevent any future misunderstandings, disagreements, or disappointments, it is vital that our patients understand our relationship with insurance companies. Please be aware that the dental insurance contract you have is between you and your company, not us and your company. We do no own, control, or influence insurance companies; thus, your company has the final decision as to what dental needs or treatment your policy will cover. Because of the complexities of dental insurance requirements, we provide assistant for you as a courtesy. However, the Primary responsibility for dealing with your company is fundamentally yours, not ours. Disagreements and misunderstanding are not between this office and the insurance company, rather between you and the insurance company. Your personal involvement will help to insure the best possible response and service. Your insurance company is far more likely to respond to requests or complaints directly from you rather than from us, after all, you, not we, pay the premiums.

In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance does not release you from your financial obligations to us. Since we have no association with insurance companies, we cannot guarantee, promise, or certify their actions or decisions. We will provide you with estimates of what your insurance company will cover based on the information that they provide us. We will do everything in our power to help you get the proper benefit, but ultimately the final decision rest with your insurance provider.

I have read and understand the above.

Signature of patient Date

Patient's Name_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Plumb and/or such associates or assistants as he/she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individuals for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide),analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, check or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serous harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desires results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me in necessary and I have been given the opportunity to ask questions.

Signature_____ Date_____

(Patient, Legal guardian or authorized agent of patient)

Witness:_____
Date_____

Plumb Dental

Consent for Photo/Image use

I, the undersigned, hereby authorize the office of Plumb Dental to use the following images to be placed in a book of case samples, or for marketing or advertising purposes:

_____ Before and after picture of my teeth

_____ Before and after picture of my full face

For Minor's only:

_____ Before and after picture of my teeth/face of my child who is under the age of 18

By signing this authorization, I waive any claims of break of privacy pertaining to the release of any photographic or digital images as checked above. I acknowledge that I have received a copy of the privacy policies of this office.

_____ _____

Signature or patient or guardian Date

_____ _____

Witness (office use only) Date