Logan Dental Associates

Patient Information

Patient Name:____Sex M F Birth Date:__________________________________

Address:____City, State, Zip____

Home Phone: ___________________________Cell Phone:_________________________Email________________________________
Do you want Text /Email reminders? (Circle one)

Employer____Phone___________________Occupation______________________

Marital Status: Married Single Widowed Divorced

Physician Name:____ Physician Phone:_____________________________

Emergency Contact_______________________________Phone___________________________Relationship___________________
How did you hear about our practice? (Circle appropriate) Patient Friend Relative Phone Book Insurance Internet Other

Name of person referring you__________________________________

Insurance Information

Responsible Party Name____Birth Date_____________________________________

Address____City, State, Zip____

Phone_______________________________________Social Sec Num____

Employer____Phone____________________Occupation____________________

Primary Insurance Subscriber Name_____________________________________Insurance__________________________________

Address____Social Sec Num____

Group Num____Relationship to Patient______________________________________

Secondary Insurance Subscriber Name__________________________________Insurance__________________________________

Address____Social Sec Num____

Group Num____Relationship to Patient______________________________________

Health Information

Circle Best Answer:

Yes No Are you in good health?

Yes No Has there been a change in your health in the last year? If yes, explain_____________________________________

Yes No Are you currently receiving care of a physician? Explain____
____

Yes No Hospitalization/Serious illness in the past three years? Explain____
____

Yes No Known Conditions____

Date of last medical exam______________________________Last dental exam______________________________

Yes No Are in in pain now? Where? Top Bottom Right Left Gums Teeth TMJ Sinus ______________________________
What? Hurts to bite Hurts to Hot Cold Sweets______________________________
How? Sharp Dull Swelling ____

Yes No Are you Pregnant? Due date___________________________

Yes No Are you Nursing?

General Health-- Circle any that apply:

Chest Pain (Angina)
Heart Attack
Heart disease
COPD
Mitral Valve Prolapse
Artificial valve
Previous Endocarditis
Pacemaker/Defibrillator
Rheumatic fever
High Blood Pressure
Heart murmur
Blood thinners
Artificial joint
Premed need
Muscle disorders

Arthritis
Stroke
Swollen feet/ankles
Swollen neck glands
Thyroid problems
AIDS/HIV
Diabetes Type 1 Type 2
Bleeding problems/bruising
Anemia
Kidney disease
Immune disorder
Tuberculosis
Persistent cough
Shortness of breath
Asthma

CPAP
Respiratory disease
Venereal disease
Frequent nausea/vomiting
Seizures
Jaundice
Liver disease/Hepatitis
Cancer
Chemotherapy
Radiation treatment
Glaucoma
Eye disease
Ulcers/GERD/Reflux
Herpes (cold sores)
Nervous problems

Substance Abuse
Recreational Drugs
Alcohol use
Psychiatric care
Dizziness
Headaches
Fainting
Blurry Vision
Head injury
ADHD
Depression
Bone density medication
Adrenal disease
Skin conditions

Explain any of the above or other known health issues
____
____
____

Dental-- Circle any that apply:

Sinus problems
TMD (pain in jaw/ear)
Difficulty Swallowing
Bad Breath
Bleeding gums

Blisters on lips/in mouth
Tobacco use
Dry Mouth
Loose teeth
Broken fillings

Mouth breathing
Sensitivity to cold/hot/sweets
Sores or growths in mouth
Tonsil problems

Metal sensitivity
Apnea/Snoring
Braces
Chewing problems
Fear of dentist

Allergies:

Latex
Local Anesthetic
Eggs

Benzodiazepines (Valium)
Penicillin
Sulfa

Aspirin
Ibuprofen
Codeine

Milk
Gluten
Antihistamines

Other____

Current Medications:

Medication	Use	Prescribing Doctor

Review

Date	Initial	BP	Update

Logan Dental Associates

Financial Arrangements

Patients who carry dental insurance must understand that all services furnished are the responsibility of the patient. This office will prepare insurance forms, however, having insurance does not release the patient from responsibility for services and the patient will be billed for those services until insurance is resolved. A rebilling charge of 1.5% per month will be assessed on any unpaid balance over 60 days. Fee estimates are based on our experience with the insurance company and are not a guarantee of insurance coverage.

I agree to pay Logan Dental Associates for professional services rendered to me at the time of service or according to a payment policy arranged by the office. I agree to pay within 30 days of billing, if credit is extended. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

Signature____Date____

Consent to Proceed

I authorize the dentist(s) 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 individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic and/or other pharmacologic agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetics may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Drops of local anesthetic or other dental agents may contact the eyes and facial tissues and cause irritation.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry such as fillings, teeth may remain sensitive or even quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After appointments, jaw muscles may be sore or tender. An open mouth can precipitate a TMJ disorder. Gums and surrounding tissue may be sensitive or painful during and after treatment. The tongue, cheek and other oral tissues may be inadvertently abraded, lacerated during routine dental procedures. Sutures or additional treatment may be required.

I understand that dental treatment items such as crowns, small dental instruments, drill components, etc may be inhaled or swallowed. This event will require a series of radiographs taken by a physician or hospital and may require bronchoscopy or other procedures for removal.

I understand the need to disclose to the dentist any and all medications, drugs or herbals taken now or in the past. Drugs taken for the treatment of osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, etc may prevent healing of the jaw bones.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired 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 have been explained to me as necessary and I will ask questions if I do not understand anything associated with my treatment.

Patient Name____Signature____
(patient, legal guardian or authorized agent)

Date_______________________________