Patient Information

Patient Name:_____ Date:_____

Male ○ Female ○ Married ○ Single ○ Child ○ Other ○

Social Security #:_____ Birth Date:_____

Phone (Home):_____ Cell:_____ Work:_____ Ext:_____

Email Address:_____ Driver's License #:_____

Physical Address:_____ Apt.#:_____

Mailing Address:_____

City:_____ State _____ Zip Code:_____

Is Email confirmation ok? Yes○ No○ Is text messaging confirmation ok? Yes○ No ○

Medical Health History Information

I consider my health to be (please circle one) Excellent Good Fair Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Liver Disease
16. Y N Jaundice
17. Y N Hepatitis - Type___
18. Y N Diabetes
19. Y N Excessive Urination and/or Thirst
20. Y N Infectious Mononucleosis (Mono)
21. Y N Arthritis
22. Y N Sexually Transmitted/Venereal Disease
23. Y N AIDS
24. Y N Herpes
25. Y N Kidney Disease
26. Y N Tumor or Malignancy
27. Y N Cancer/Chemotherapy
28. Y N Radiation Treatment
29. Y N History of Drug Addiction
30. Y N Immune Suppressed Disorder
31. Y N Hearing Loss
32. Y N Fainting Spells
33. Y N Glaucoma
34. Y N History of Emotional or Nervous Disorders
33. Y N Implants/Artificial Joints: Hip Knee Other
34. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?____
35. Y N I have consumed alcohol within the last 24 hours.
36. Y N I usually take an antibiotic prior to dental treatment.
37. Y N Have you ever taken Fen-Phen or Redux / Fosamax, Actonel, Boniva or any other biphosphonate?
38. Y N Have you experienced pain or clicking in your jaw or other TMJ symptoms?

WOMEN

39. Y N Are you taking birth control medication?
40. Y N Are you or could you be pregnant or nursing?

41. Y N I have had major surgery: Year_____Type of operation:_____
42. Y N Do you have any other medical problem or medical history NOT listed on this form?_____
43. Y N Do you have any health problems that need further clarification? If yes, please explain:_____

Are you allergic to any of the following?
Please circle Y for yes or N for no

43. Y N Aspirin
44. Y N Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local Anesthetics (Novocain)
50. Y N Other Medications – Which ones?_____

_____

Please list all medications you are currently taking:

Medicine_____
Condition_____
Medicine_____
Condition_____
Medicine_____
Condition_____
Physician's Name_____Phone_____
Address_____Fax_____

Date of Your Last Dental Visit: _____ What is the reason for *this* visit:_____

_____

Previous Dentist's Name:_____ Phone:_____

In the event of an emergency please contact:

Name_____Relationship_____Phone_____

Have you ever had any complications following dental treatment? (circle Y for yes or N for no) Y N
If yes, please explain:_____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? Y N
If yes, please explain:_____

_____

Are you now under the care of a physician? Y N
Name of physician:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice?

- o Another patient (friend/relative)
- o Dental Office
- o Newspaper
- o School
- o Work
- o Internet
- o Other:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Office policy's and Agreement

Treatment Policy

Please note that all treatment plans are subject to change during the course of treatment. These treatment recommendations have been diagnosed from visual and radiographic documentation. Treatment is suggested and performed at Dr. Pruett's discretion and recommendation. As a courtesy to our patients we present all new patients with a copy of entire treatment recommendations along with treatment plan estimates for your information. Any questions in regards to treatment should be addressed at consultation appointment.

Cancellation Policy

In order for our schedule to run as smoothly as possible we require 48 hour business day notice for cancelled and rescheduled appointments. We will be enforcing a $50.00 fee for those patients who do not have the courtesy to give us adequate notice. We are more than willing to be flexible with rescheduling with notice.

Financial Policy

It is policy in our office to pay as treatment is rendered. We do as a courtesy to our patients bill insurance companies however we are not a participating provider for any company other that Delta Dental of California. Due to the fact that we are not contracted with any companies it is patients financial responsibility for all co-payments, deductibles, and any services considered not to be covered by your plan participating or not.
Payment is due at time of service unless other arrangements have been previously made. We bill within usual and customary fees for our area, if there are any questions in regards to fee schedule please address these issues before time of service.

FOR YOUR PAYMENT CONVENIENCE WE DO AT THIS TIME ACCEPT CASH, CHECK, OR CREDIT CARD.

I have read and understand the above office and financial policy:

_____ _____

Signature (patient or responsible party) Date

Richard Pruett, DDS
Orthodontics/TMJ Dysfunction

Patient Name: _____ **Date:** _____

HEALTH QUESTIONNAIRE

Chief Concern: _____
Date of Onset: _____

PAIN SYMPTOMS:

Do you get "tension headaches"	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you ever get "migraine headaches?	Y	N	Do you get headaches in the back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N	Do you grind your teeth when asleep?	Y	N
Do you have trouble sleeping soundly?					
Have your teeth been sore upon awakening?	Y	N	Are you jaws tired when you awaken from sleep?	Y	N
Does your jaw ache when you chew?	Y	N			
Do you have ear pain?	Y	N	When are your symptoms the worse? _____		
Does your jaw ache when you open wide?	Y	N	_____		
Have you ever had chronic shoulder or back pain?	Y	N	Does anything make you feel better? _____		
What medications, if any, are you taking?			_____		
_____			Have your wisdom teeth been extracted?	Y	N
_____					

How often do you take medication for relief of pain?

☐ Never ☐ Weekly
☐ Daily ☐ Monthly

TRAUMA OR ACCIDENTS:

Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Have you ever "whiplash"?	Y	N	Details: _____		
			_____		

JAW JOINT SYMPTOMS:

Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear a "clicking", "popping" or "cracking" noise from either jaw joint?	Y	N
Are there any foods you avoid eating?	Y	N			
Do you ever get dizzy?	Y	N	Has your jaw ever locked where you were unable to open or close?	Y	N
Do you ever feel faint?	Y	N			
Do you feel nauseated (sick)?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N	Have you ever had pain in either jaw joint?	Y	N

EAR AND EYE SYMPTOMS:

Do you have itchiness or stuffiness in either ear?	Y	N	Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N	Do you hear grating noises in ears? (Like sand particles rubbing together)	Y	N
Do you get pain in, around or behind either eye?	Y	N	Do you wear glasses or contacts?	Y	N
Are there times when your eyesight blurs?	Y	N			

BREATHING:

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N			

Richard Pruett, DDS
General Dentristry\ Orthodontics\ TMJ Dysfunction

To provide the highest quality treatment we have created this little questionnaire to find out what your expectations are for your dental care here in our office. We would also like you to know that there are several levels of treatment available and this will help us to build a treatment plan that is suitable for each and every patient on an individual basis.

Please answer the following questions:
What is your chief complaint or concern in regards to your dental care?

_____

_____

Are you concerned or interested in the esthetics(cosmetics) of your teeth?_____

Please # 1-5 the areas of greatest concern: (1 being the most important)

__ True Overall Health
__ Cost
__ Time
__ Pain
__ Esthetics(Looks)
__ Function

Below are explanations of the levels of treatment in our office. Please review and circle the level of treatment that best suits your wants:

Level 1: Emergency Care, This level of care would be for the patient whom is only interested in addressing problematic teeth or the teeth that they are currently experiencing pain from.
Level 2: Minimal Maintainance Care, This would include periodic exams, cleanings that the insurance will pay for and any necessary restorative work to eliminate large decay. This would include that teeth that could be problematic in the near future.
Level 3: Restorative Care, Care to maintain healthy teeth and gums this would include exams, all necessary cleanings as deemed by hygenist, x-rays, and restorations of teeth that have decay or existing amalgum fillings to be replaced with composite restorations.
Level 4: Reconstruction, This would include the above stated levels of treatment but will also include reconstruction using bridges, implants, or partials where necessary.
Level 5: Ortho\TMj\Cranial: Levels 1-4 plus any necessry orthodontic treatment to insure that the Craniomandibular Joint is in the correct and healthy position. This level of treatment would include proper alignment of the cranial and skeletal systems. Orthodontics to make the teeth not only esthetically pleasing but also proper functionality. This would be considered overall health. Dr. will also advise as to what nutritional supplements may be helpful in the course of treatment.
Level 5A: This level of treatment would be for the health conscious patient that does not present with any Cranio-Mandibular problems but is interested in true health structurally and nutritionally.
Feel free to discuss any questions or concerns you may have in regards to the levels of treatment or any other question you may have. Please remember that non-painful symptoms does not mean that you're at optimal health.