Flower Dental

Jeff Flower, D.D.S.
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Carrollton, TX 75010

972-306-2273 (CARE)
www.flowerdentalcare.com

* * * PATIENT INFORMATION * * *

Name _____ **Soc Sec #** _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Employer Name _____ **e-mail Address** _____

If married: **Spouse's name** _____ **Spouse's employer** _____ **Spouse's Day Phone:** _____

How did you learn about this office?
___ drive by / sign **___ Delta Dental** **___ Advertisement: name** _____

___ referral card **___ on-line / internet** **___ Patient referral: name** _____

Person Responsible for this Account: _____ **Relation to Patient:** _____

If different from above – **Address** _____ **Day Phone**_____ **Other Phone** _____

Authorization for Services (Please initial each of the following items.)

_____ ***I authorize Dr. Flower to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of the patient's dental needs.***

_____ ***For each treatment I accept, I authorize Dr. Flower to perform any procedure indicated in connection with said patient and employ such assistance as he deems fit.***

_____ ***I understand that the use of local anesthetics embodies a possible risk.***

_____ ***I understand that I am responsible for payment for Dental Services provided in this office for myself and/or my dependents and that payment is due and payable at the time services are rendered unless financial arrangements have been made.***

_____ ***I understand that a 1 ½% finance charge may be added to any balance over 30 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees required to effect collection of this note.***

_____ _____
signature of patient or guardian ***date***

* * * INSURANCE INFORMATION * * *

Insurance Company _____ **Group #** _____ **Phone** _____

If the patient is NOT the primary person with insurance coverage:

Name of Insured _____ **Relation to Patient** _____ **Date of Birth** _____

Soc Sec # / Member # _____ **Employer Name** _____ **Work Phone** _____

Authorization, Release and Agreement to Pay for Services (Please initial each of the following items.)

_____ ***I authorize Dr. Flower to release to third-party payors and/or other health practitioners any information regarding my dental care, including the diagnosis and the records of any treatment or examination rendered to me during the period of my dental care.***

_____ ***I authorize and hereby request my dental insurance company to pay directly to Jeffrey L. Flower, D.D.S., P.A, those insurance benefits otherwise payable to me.***

_____ ***I understand that dental insurance is seldom intended to pay 100% of the fee for dental treatment. I acknowledge that I am responsible for any amount not covered by my dental benefit plan. This includes occurrences when the plan fails to pay Dr. Flower in a timely manner in spite of being provided with documentation of treatment.***

_____ _____
signature of patient or guardian ***date***

MEDICAL HISTORY

Patient Name _____ **Date** _____

Welcome to Flower Dental! Please complete both sides of this Medical/Dental History form. Your truthful, complete answers will allow Dr. Flower to provide the best, safest treatment for you. All information is completely confidential.

Are you in good health? Yes No If no, explain: _____

Any change in your health in the last year? Yes No If yes, explain: _____

_____

Any serious illness, operation or hospitalization within the past 5 years? Yes No

If yes, describe: _____

Medication(s) you currently take, including non-prescription, vitamins, diet pills, & homeopathic or "natural" remedies

Please list: _____ _____

Are you currently under the care of a physician? Yes No If yes, for what? _____

Date of your last physical exam (month/year) ____/____ Physician Name/Phone _____

DISEASES/PROBLEMS: Do you currently have or have you had any of the following? *Please circle an answer for each.*

Heart valve damage, artificial valves, or heart murmur	Yes	No	Thyroid problems	Yes	No
Rheumatic heart disease	Yes	No	Respiratory problems, emphysema, bronchitis	Yes	No
Heart attack, angina, high blood pressure, stroke, other heart trouble	Yes	No	Arthritis or painful, swollen joints including jaw joint (TMJ).	Yes	No
Arteriosclerosis or other heart condition	Yes	No	Stomach ulcer or hyperacidity	Yes	No
Chest pain upon exertion.	Yes	No	Kidney trouble	Yes	No
Shortness of breath after mild exercise	Yes	No	Tuberculosis.	Yes	No
Ankle swelling	Yes	No	Cough: persistent or produces blood	Yes	No
Allergies: seasonal	Yes	No	Neck glands: persistently swollen	Yes	No
Sinus trouble	Yes	No	Blood pressure: low	Yes	No
Asthma, hay fever	Yes	No	Epilepsy, neurological disorder	Yes	No
Fainting spells, seizures	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Depressed immune system caused by any disease, drug or transplant operation	Yes	No
Hepatitis, jaundice, liver disease	Yes	No	Anemia, any type of blood disorder	Yes	No
Mouth sores: frequent or recurring	Yes	No	Abnormal bleeding	Yes	No

PRIOR TREATMENT: Have you ever had any of the following treatments? *Please circle an answer for each.*

Osteoporosis medication	Yes	No	Artificial joint replacement	Yes	No
Blood transfusion	Yes	No	Radiation therapy	Yes	No
Heart pacemaker.	Yes	No	Steroid injections	Yes	No

ALLERGIES: Are allergic to or have you had a reaction to any of the following? *Please circle an answer for each.*

Aspirin, ibuprofen, naproxen	Yes	No	Penicillin	Yes	No
Anesthetics, local	Yes	No	Sulfa drugs	Yes	No
Barbiturates or sleeping pills.	Yes	No	Other antibiotics	Yes	No
Codeine	Yes	No	Latex gloves	Yes	No
Iodine	Yes	No	Other medication _____	Yes	No
Narcotics	Yes	No	_____		

WOMEN *Please circle an answer for each.*

Pregnant or trying to become pregnant	Yes	No	Birth control pills	Yes	No
Nursing	Yes	No			

TOBACCO USE *Type and Frequency* _____

OTHER CONDITIONS/DISEASES: Anything else Dr. Flower should know _____

I acknowledge that I understand the above and have answered each question completely and correctly. I will not hold Dr. Flower or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient (or guardian) Signature: _____ Date: _____

Patient Name _____ **Date** _____

DENTAL HISTORY

What is the reason for your visit today (any problem/ concerns, etc.? _____

_____

YOUR RECENT DENTAL TREATMENT

Dental Visit _____ (month / year) Cleaning/Hygiene Treatment _____ (month / year) Full Mouth X-Rays _____ (month / year)

What treatment did you receive at your last dental visit? _____

Has a dentist recommend treatment that you have not received yet? Yes No

If yes, what type of treatment was it? _____

Why was this treatment not performed? _____

YOUR DENTAL HABITS

How often do you :

Brush your teeth _____ Floss _____ Dental exams _____ Cleanings: _____

Toothbrush: Which do you use? ___ Manual ___ Sonicare ___ Other _____

Nightguard Yes No Orthodontic retainer Yes No CPAP/sleep breathing device Yes No

CONDITION OF YOUR GUMS

Bleeding when you brush or gums that hurt	Yes	No	Mouth odors or bad breath	Yes	No
Loose teeth or change in your bite	Yes	No	Parents have had gum disease or tooth loss . . .	Yes	No

PRIOR DENTAL TREATMENT

Periodontal treatment for gum disease	Yes	No	Oral surgery	Yes	No
Orthodontic treatment, braces	Yes	No	Implants	Yes	No

NEUROMUSCULAR SYMPTOMS

Clicking or popping of the jaw	Yes	No	Head, neck or facial pain	Yes	No
Sore jaw, especially in the morning	Yes	No	Ringing in your ears	Yes	No
Difficulty opening mouth wide	Yes	No	Numbness in fingertips	Yes	No
Difficulty chewing or swallowing	Yes	No	Tooth sensitivity to pressure or hot/cold	Yes	No

SLEEP

Snore loudly (louder than normal talking)	Yes	No	Sleep apnea, gasp then wake up, ...	Yes	No
Feel tired or sleepy during the day	Yes	No	told you stop breathing while asleep		

YOUR DENTAL PRIORITIES Please identify TWO dental values that are most important to you.

____ Appearance, how good your smile looks
____ Comfort, avoidance of discomfort or pain
____ Longevity, getting quality dental work lasts
____ Long-term cost effectiveness, least overall cost to you

Do you want to keep your teeth for the rest of your life? Yes No

Are you nervous about dental treatment? Yes No If yes, please explain. Did you have an upsetting dental experience?

_____

Is there anything else Dr. Flower should know? _____

I acknowledge that I understand the above and have answered each question completely and correctly. I will not hold Dr. Flower or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient (or guardian) Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

_____ received a copy of the **Notice of Privacy Practices** for this office.
Please Print Name

_____ _____
Signature Date

If Patient Refuses to Sign This Acknowledgement

We were unable to obtain written acknowledgement of receipt of our **Notice of Privacy Practices** because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____