Adult Examination

Mailing address:
Po Box 1433
Williston, VT 05495

Physical Address:
5063 Williston Rd
Williston, VT 05495

PLEASE PRINT **TODAY'S DATE:**_____

Name _____

Has your name changed in the last 3 years?____ If yes, previous name_____

Date of Birth_____ Age_____ Sex _____ Marital Status_____

Social Security #_____

Mailing Address:_____City_____ State_____ Zip _____

Street Address:_____ City_____ State_____ Zip _____
(if different from your mailing address)

Home Phone: _____ Cell Phone:_____ Business Phone: _____

E-Mail Address: _____

Preferred Appointment Reminder Method: (Please Circle) Call Text Email

(Our office will send an E-mail the day appointment is made as well as Email/texts reminder one week and day before an appointment.)

Employee Name:_____Occupation:_____

Employer Name & Address:_____

Name of Dental Insurance Carrier: _____

Subscriber ID#: _____ Group # _____

Spouse/Partner Name:_____Date of Birth:_____

Social Security #:_____ Phone Number: _____ Home Cell

Employer Name:_____ Occupation: _____

Employer Address:_____ Business Phone: _____

Name of Dental Insurance Carrier: _____

Subscriber ID#:_____ Group #:

Who will pay for this account? _____ Relationship to you _____

Address:_____ City:_____ State:_____Zip:_____

Home Phone:_____ Business Phone:_____

Is anyone else in your family a patient here?_____

Whom may we thank for referring you? _____

MEDICAL RESPONSE:

Name and Address of Physician: _____ Pharmacy: _____

Have you been a patient in a hospital during the past 2 years? For? _____

Have you been under the care of a physician during the past 2 years? For? _____

Have you taken any kind of medicine or drugs during the past year? _____

Name of Medications: _____

Have you had any other serious illnesses? _____

Are you allergic to penicillin or any drugs or medications? **Allergic to:** _____

Have you ever had any excessive bleeding requiring special treatment? _____

Have you ever had a blood test for hepatitis? _____

Have you ever had an adverse reaction to local anesthetic or other drug? **Reaction to:** _____

Please check any of the following conditions which you have had or have now:

- ❑ AIDS
- ❑ Allergies
- ❑ Anemia
- ❑ Artificial heart valves
- ❑ Artificial joints/pins
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorders
- ❑ Cancer treatment
- ❑ Cardiac pacemaker
- ❑ Congenital heart lesion
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart murmur
- ❑ Heart trouble (surgery)
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood pressure
- ❑ HIV
- ❑ Jaundice
- ❑ Kidney treatment
- ❑ Latex allergy
- ❑ Metal allergy
- ❑ Rheumatic fever
- ❑ Sinus trouble
- ❑ Stroke
- ❑ Tuberculosis

Do you have any disease, condition or problem not listed? Explain: _____

Do you smoke or use tobacco products? _____

Do you have a History of chemical dependency? _____ Are you in recovery? _____ If Yes, how long: _____

If female, are you pregnant now? _____

DENTAL RESPONSE:

Purpose of Initial Visit _____

Are you aware of a problem? _____

How long since your last dental visit? _____

RELEASE AND CONSENT:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees will be made to me concerning the results of this treatment or procedure.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions, pain, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs).

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date: _____

Dental and Oral Health Information

Patient's name_____ Date_____ Please describe any specific dental problem or discomfort you are having at this time_____
_____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery _____
"Braces" or any type of orthodontic treatment: _____ Dental implants:_____ Any other type of oral surgery: _____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

Your Dental Health:

How do you rate your overall dental health? ☐Good ☐Fair ☐Poor

How many times a day do you brush your teeth?_____ How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)	Yes	No
Mechanical (electric) toothbrush If Yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.)	___	___
Oral irrigating device (Waterpik)	___	___
Fluoride treatments or supplements at home. If Yes, which ones: _____	___	___
Mouthwashes or oral rinses. If Yes, what brand? _____	___	___
Do you have any missing teeth that have not been replaced?	___	___
Why have you not had them replaced? _____		
Do you wear any removable dental appliances?	___	___
If Yes, what type and for how long? _____		
Have you ever had your teeth whitened or bleached?	___	___
Would you like to have your teeth whitened or bleached?	___	___

How do you feel about the appearance of your smile and what would you change if you could?

_____

Are you concerned about the finances required to return your mouth to excellent health	___	___
Are you frustrated because you always need something treated or repaired when you visit a dentist?	___	___
Do you feel you will eventually wear artificial dentures?	___	___
Have you ever had any complications from an extraction or dental treatment?		
If Yes, please explain: _____		
Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth?	___	___
If Yes, please specify: _____		
If you are a new patient to this practice:	___	___

Date of last dental visit_____ Dentist's name_____ City & State_____

Reviewed By: _____

Williston Road Family Dental

General Dental Treatment Consent Form

Patient Name: _____

Drugs, Medications and Local Anesthetics **Initials** _____

I understand the antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthetic that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling or numbness that may persist for several weeks, months, or permanent. I have informed my dentist of my complete medical history, including any recent surgeries, changes in medical history and any known allergies.

Fillings **Initials**_____

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (caps) and Bridges **Initials**_____

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown or bridge (including shape, fit, size, and color) will be before cementation. Once cemented, I understand that any changes to shape, fit, size or color will incur additional charge.

Changes in Treatment Plan **Initials**_____

I understand that during treatment, it may be necessary to change and or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon consent I will give permission to the dentist to make any/all changes and additions as necessary

Alternative treatment **Initials**_____

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. The treatment plan chosen by me may/may not be the procedure that your providing dentist prefers.

Out of office referrals **Initials**_____

In the event we refer you for treatment not rendered in this office, i.e. Oral surgery, root canal therapy, periodontal therapy, orthodontics etc. I give permission for my necessary records to be e mailed to the referring doctor.

By signing below, I consent to the general dentist treatment and or proposed treatment agreed by my primary providing dentist and myself.

Patient/Guardian Signature: _____ Date: _____

Williston Road Family Dental

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover and Care Credit

Payment for services is due at the time service rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time of prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date of previous arrangements have been made with the doctor or billing receptionist.

Checks that are returned to our office from the financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated Most benefits will be verified before your insurance company can be billed.

All insurance co pays, which would include deductible must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promp

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy, I understand and agree to this Policy, and filled out the back of form as needed.

Signature of Patient or Responsible party:_____ Date:_____

Williston Road Family Dental
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____have received a copy of this office's Notice of Privacy Practices.
Print Name: _____
Sign: _____
Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I,_____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

Mailing address:
PO Box 1433
Williston, VT 05495

Physical address:
5063 Williston Road
Williston, VT 05495

Photo Consent

I hereby authorize Williston Road Family Dental employees to take photographs and/or videos of my face, jaws, teeth, and oral structures before, during and after treatment as part of my dental record.

I consent to allow the photographs to be used for the following:

- Used by laboratories for restoration fabrication
- Dental research
- Dental education: including professional articles, lectures, study groups, and presentations
- Marketing material: including, but not limited to practice website, social media, printed materials, and patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos. I hereby release Williston Road Family Dental and it's employees from any claims in connection with these materials.

Patient Name:

_____

Patient or Legal Guardian Signature:

_____

Date:

_____