Patient Information Date: ______________________

Name: ___________________________________ _______________ Soc. Sec #: _____________________

Address: ____ D. L. #: _______________________

City: ____________________________State: ______ Zip: _________ E-Mail: _______________________

Cell Phone: __________________Home Phone: __________________Work Phone: ____________________

Sex: ◯ M ◯ F Age: _________Birthdate: _____________________ ◯ Minor ◯ Single ◯ Married

Patient Employer/School: _____________________________________ Occupation: __________________

Employer Address: ____ Phone #: _____________________

How would you like our office to confirm your appointments? ◯ Phone ◯ Text ◯ E-mail

In case of emergency, who should be notified? ____________________________Phone # __________________

Referral Information – Whom may we thank for referring you to our practice?

◯ Patient/Friend ◯ Our Staff ◯ Yellow Pages ◯ Work ◯ Our Sign ◯ School ◯ Work

◯ Patient/Relative ◯ Newsletter ◯ Website ◯ Facebook ◯ Google ◯ Other ___________

Name of the person or office referring you to our practice: ____

Medical History

Physicians Name: ____Phone #: _____________________

Have you had any serious illnesses or operations? Yes ◯ No ◯ If Yes, Describe: ___________________________

Are you taking any blood thinners? Yes ◯ No ◯ Please List: ____

Do you have to be pre-medicated before any dental treatments? ◯Yes ◯No Reason: ________________________

Do you have any other medical problem or medical history NOT on this form? ◯ Yes ◯ No

Please List: ____

***Pharmacy: ___________________________________Phone: _____________________**

Sleep Wellness:

Has anyone ever told you that you snore? ◯ Yes ◯ No

Do you often feel tired, fatigued, or sleepy during the day? ◯ Yes ◯ No

Has anyone observed you stop breathing during your sleep? ◯ Yes ◯ No

Do you use a CPAP machine? ◯ Yes ◯ No

WOMEN ONLY

Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

Check if you have or have had any of the following:

◯ Anemia
◯ Arthritis
◯ Artificial Heart Valve
◯ Artificial Joints
◯ Asthma
◯ Back Problems
◯ Cancer
◯ Chemotherapy
◯ Diabetes
◯ Epilepsy
◯ Fainting
◯ Headaches
◯ Heart Problems
◯ Hepatitis
◯ High Blood Pressure
◯ HIV/AIDS
◯ Jaw / TMJ Pain
◯ Liver/Kidney Disease
◯ Mitral Valve Prolapse
◯ Pacemaker
◯ Respiratory Disease
◯ Rheumatic Fever
◯ Stroke
◯ Use Tobacco/Smoke

Are you allergic to any of the following?

◯ Penicillin ◯ Aspirin ◯ Local Anesthetics ◯ Codeine ◯ Latex ◯ Sulfa Drugs
◯ Other ____

Please list all medications you are currently taking

Medicine ______________________ Condition ______________________
Medicine ______________________ Condition ______________________
Medicine ______________________ Condition ______________________

Dental History

Reason for today's visit: ______________________________________
Previous Dentist: ______________________ Last Visit: ______________________
Reason for changing dentist: ______________________________________
Are you nervous about seeing a dentist? ◯ Yes ◯ No If yes, please tell us why:______________________

Are any of your teeth sensitive?	Yes	No	I have problems eating	Yes	No
I clench/grind my teeth	Yes	No	I have had orthodontics	Yes	No
My gums bleed while brushing/flossing	Yes	No	I like my smile	Yes	No
I have loose teeth or broken fillings	Yes	No	I want my teeth straight	Yes	No
I hear clicking or popping in my jaw	Yes	No	I want my teeth whiter	Yes	No

Responsible Party
Name of insurer: ______________________ Social Security# ______________________
Relationship to patient: ______________________ Birthdate: ______________________
Address (if different from patient): ______________________________________
City: ______________ State: __________ Zip: __________ Cell Phone: ______________________
Person insured employed by: ______________________ Occupation: ______________________
Insurance Company: ______________________ Phone #______________________
Group #: ______________________ Subscriber: ______________________
Name of other dependents covered under plan: ______________________________________

We accept Cash, Check, Visa, Mastercard, Discover
Financing available through Care Credit - Ask us how!

As a courtesy, we are happy to assist you in filing your dental insurance. We are an out of network provider for most insurance companies. We will collect your estimate portion on the day of service and will wait 30 days to obtain the balance from your insurance company. Any portion not paid by your insurance company in 30 days will be collected from the patient. Our doctors will provide dental care based on your needs and will not be based on what your insurance may or may not cover. Our goal is to provide you with exceptional service in obtaining excellent oral health.

The patient or guarantor is responsible for the fee at the time of treatment unless prior arrangements have been approved.

I understand that the fee quoted will be valid for a period of 12 months from the date of the patient examination. I hereby authorize payment to Cleveland Family Dentistry for my insurance benefits. I understand that I'm ultimately responsible for all costs for the dental treatment. I grant the right to Cleveland Family Dentistry to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient Insured: ______________________________ Date: ______________________

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party-payers
- Conduct normal healthcare operations such as quality assessments and physician certificate.

I acknowledge that I received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time at the address below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

CONSENT TO GIVE INFORMATION

I, ____give permission to Dr. Uhrenholdt and his employee/associates to give information to the people/persons listed below regarding financial information and treatment needed. I am aware of my rights to privacy, HIPPA notice of privacy practices act of 1996, and release Dr. Uhrenholdt and his employees/associates from any liability concerning the release of this information.

Name:_____________________________________ Relationship:____________________________

Name:_____________________________________ Relationship:____________________________

Name:_____________________________________ Relationship:____________________________

Name:_____________________________________ Relationship:____________________________

Signature:_______________________________________ Date:______________________________

Witness:____ Date:______________________________

Dental Insurance Information and Disclaimer

Please **READ** carefully before signing.
Please initial each section.

___________ It is our pleasure to assist you with any insurance questions or problems you may have. Unfortunately, it is difficult to predict the benefits or restrictions your insurance company has in place. We will give you an estimate of your financial responsibility for any procedure before you are seen. **Please understand this is just an estimate.**

___________ Please understand many dental plans have waiting periods, frequency limitations, and alternate benefits. We will give you a comprehensive treatment plan with your best interest in mind, regardless of whether dental insurance may contribute.
You will be responsible for any difference in amounts your insurance does not pay.

___________ I do fully understand that Cleveland Family Dentistry has agreed to file my insurance as a courtesy and that I am fully responsible for any treatment costs which are denied or not covered by my insurance company. I further agree that it is my responsibility to know the extent of my benefits, restrictions and limitations.

____
Patient Signature or Parent of Minor