

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush?	_____	_____
How often do you floss?	_____	_____
Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes: _____

_____ Date: _____

Women

	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Notes: _____

Patient/Parent Signature: _____

Dentist Initial: _____

Medication List

Because you may be prescribed medications or have anesthesia within our office, we will need a **Full List** of all medications (over the counter, vitamins, etc). This is for a completeness of you Medical History and so that we do not have any **Adverse Reactions** with **Certain Medications**.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

PATIENT CONCERNS

Here at Life Style Dentistry we strive to give the Best Customer Service Available. To better serve you and to understand your concerns or wants please check all the following items that apply to you.

FEAR OF:

- Hand piece noises
- Pain during or after treatment
- Gagging
- Getting numb
- Being Criticized or Embarrassed
- Past negative dental experiences
- Not understanding the Necessary Dental Treatment
- The overall fear is Paralyzing

Smile Concerns:

- Would you like to change the size or shape of your teeth.
- Have Gaps or Spaces
- Stained Yellow or Brown teeth
- Replace Missing Teeth
- Small or Pointy Teeth
- Crowded Teeth
- Worn or Eroded Teeth

Would Like to Know more About:

- Invisalign
- Veneers
- Implants

- **Whitening options**
- **Perio Protect**
- **Financial Options**

Thank You!



4001 Financial Parkway • Rogers, AR 72758

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name: _____

Patient Date of Birth: _____

- I do not authorize** the release of any dental information to *any individual* except for treatment, payment and health care operations as specified in **Life Style Dentistry's** Notice of Privacy Practices.
- I hereby authorize** the release and disclosure of my dental information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: statements of charges or payments, records of all visits, records of visits for any and all dates, copies of records or reports provided to specialists, progress notes and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected dental information.)

Name	Relationship to Patient

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy or fax of this authorization is as valid as the original. 3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist. 4. Life Style Dentistry, its employees, officers, and dentist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent of indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is not longer protected.

Patients Printed Name

Patients Signature

Date

Dr. Hubbs would like all of her patients to have knowledge of risks and benefits of dental procedures. We ask that you review the procedures listed and feel free to ask any questions. A treatment plan for all restorative work, which includes **anticipated fees** and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Drugs and Medication:** Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness or bruising.
2. **Changes in Treatment:** During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
3. **Removal of teeth:** Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc). The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.
4. **Crowns and Bridges:** Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
5. **Partials/Dentures:** They are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances, including looseness, soreness, and possible breakage. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee.
6. **Endodontic Treatment (Root Canal):** There is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment and occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. Occasionally additional surgical procedure may be necessary following root canal treatment (apicoectomy). This treatment may be done with an Endodontist.
7. **Periodontal Loss (Tissue & Bone):** This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacement, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal condition. This treatment may be done with a Periodontist.
8. **Implants:** They are a permanent alternative to bridges, partials or dentures. This process involves the participation of an oral surgeon or a periodontist. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.
9. **Sealants:** There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years as long as the patient is seen twice a year for the prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them done.
10. **Sedative Fillings:** Sedative fillings are temporary. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, than the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth.

Treatment risk: I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, biting sensitivity, abscess, pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient Signature or Guardian _____ Print Patient Name

Date _____