Medical and Dental History

Patient Name: _____ Date of Birth: _____

Physician name: _____ Phone: _____

Date of last physical exam: _____Are you currently under the care of a physician? _____

If yes, please explain: _____

Have you had or do you currently have any of the following conditions?

Abnormal Bleeding	☐Yes ☐No	Diabetes	☐Yes ☐No	Kidney Problem	☐Yes ☐No
Acid Reflux	☐Yes ☐No	Difficulty Breathing	☐Yes ☐No	Liver Disease	☐Yes ☐No
Alcohol Abuse	☐Yes ☐No	Drug Abuse	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Allergies	☐Yes ☐No	Emphysema	☐Yes ☐No	Loss of Appetite	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting Spells	☐Yes ☐No	Loss of Sleep	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Fever Blisters	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Anorexia/ Bulimia	☐Yes ☐No	Frequent Headache	☐Yes ☐No	*Regurgitation* ☐*Yes* ☐*No*	
Arthritis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Pacemaker	☐Yes ☐No
Artificial Bones	☐Yes ☐No	Hay Fever	☐Yes ☐No	Pain in jaw Joints	☐Yes ☐No
Artificial Heart	☐Yes ☐No	Heart Attack	☐Yes ☐No	Pulmonary Shunts	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Heart Disease	☐Yes ☐No	Psychiatric Problems	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Failure	☐Yes ☐No	Radiation Therapy	☐Yes ☐No
Artificial Prosthesis	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Asthma	☐Yes ☐No	☐*Physiological* ☐*Functional* ☐ *Innocent*		Seizures	☐Yes ☐No
Bacterial Endocarditic	☐Yes ☐No	Heart Surgery	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Hemophilia	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Hepatitis	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	☐*A* ☐*B* ☐*C*		Thyroid problems	☐Yes ☐No
Chest Pain	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Colitis	☐Yes ☐No	HIV	☐Yes ☐No	Ulcers	☐Yes ☐No
Congenital Heart Defect	☐Yes ☐No	AIDS	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No

Are you allergic to any of the following medications?

Aspirin	☐Yes ☐No	Codeine	☐Yes ☐No	Sulfa	☐Yes ☐No
Nitrous Oxide	☐Yes ☐No	Clindamycin	☐Yes ☐No	Latex	☐Yes ☐No
Dental Anesthetics	☐Yes ☐No	Valium	☐Yes ☐No	Metals	☐Yes ☐No
Penicillin	☐Yes ☐No	Other: _____			

List any medicines you are currently taking: _____

Are you currently pregnant or trying to get pregnant? ☐Yes ☐No

Is there any other medical information not included above which you feel we should be informed about? ☐Yes ☐No

If yes, please explain: _____

What prompted you to seek dental care at this time? _____

How long has it been since your last thorough dental examination?_____

When were your teeth last cleaned? _____ X-rayed? _____

Have you had any previous periodontal therapy? If yes, please list the provider and dates: _____

_____

Have you had any bad experiences in a dental office? _____

If yes, please explain: _____

_____

Are you troubled with bad breath? ☐Yes ☐No

Do your gums bleed easily, feel tender or irritated? ☐Yes ☐No

Are there areas in your mouth where food sticks or get caught? ☐Yes ☐No

Are you self-conscious about the appearance of your teeth? ☐Yes ☐No

If yes, please explain: _____

Do your jaws feel tired or sore? ☐Yes ☐No

Do you experience excessive headaches and/or pain in the neck, shoulders or back? ☐Yes ☐No

Do you experience clicking or popping noises when opening or closing your mouth, or when chewing? ☐Yes ☐No

Are you aware of grinding or clenching your teeth? ☐Yes ☐No

Do you use any tobacco products? ☐Yes ☐No

What, if anything, would you do to change the appearance of your teeth? _____

_____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Dr. Butler and/or her trained staff to take X-rays, study models, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Biodent and/or their trained staff to present my treatments needed according to their findings. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

_____ _____

Signature of Patient/Parent or Guardian Date

_____ _____

Reviewed By Date

Patient Information

Patient Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss _____

Address: _____

City: _____ State: _____Zip: _____

Mailing Address (if different from above): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Name of person responsible for account: _____

Address/ Phone (if different from above): _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

By what name do you prefer to be called? _____Preferred method of contact_____

Is it ok to leave personal voicemail or email messages? YES_____ NO_____ (check one)

Are Text Messages OK? Yes_____No_____

FINANCIAL AGREEMENT

I understand that all responsibility for payment for dental provided in the office for my dependents or myself is mine, due and payable at times services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon date. I understand that a 1.5% finance charge (18% APR) may be added to my account.

COLLECTION PROCEEDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees. In addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS

I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a 24-business hour notice. Failure to do so will result in a cancellation fee.

RETURNED CHECKS

I understand that there will be a $35.00 insufficient funds fee added to my account in the event of a returned check.

CHANGE OF INFORMATION

I understand that it is my responsibility to advise this office of any change in the information I provide regarding my insurance, patient information, or the health history form.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVVACY PRATICES

I have received a copy of this office's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment.

_____

Responsible Party Signature Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

Printed Name of Patient or Representative

Signature _____Date_____

Relationship to Patient (if other than patient): _____

Witness: _____

Printed Name of Practice Representative

Signature_____ Date_____

BIODENT

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by state and federal law, and not buy a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. _____**INITIALS**

Article 2: All Claims Must be Arbitrated: It is also understood that dispute that does not relate to medical malpractice, including disputes as to whether or not dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient, whether born or unborn, at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as backup for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office where signatories to this form are not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the healthcare providers associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked. _____**INITIALS**

Article 3: Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or

other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The party's consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention in joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law where applicable establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.
_____INITIALS

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. **_____INITIALS**

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties. **_____INITIALS**

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), arbitration shall be effective as of the date of first professional services. **_____INITIALS**

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provision shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive copy of this arbitration agreement by my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU'RE AGREEING TO HAVE ANY ISSUE OF DENTAL/MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.

I hear by agree to have **ANY** issue of dental/medical malpractice decided by neutral arbitration and give up my right to a jury or court trial.

_____	_____	_____
Printed Name	**Signature**	**Date**