Fabey Dental

Passion ~ Possibilities ~ Precision

Patient Information

(ALL areas that apply must be filled out & SIGNED)

Patient Name_____ Date of Birth_____

Address_____ City _____ State _____ Zip _____

Home Phone_____ Cell Phone_____

S.S. #_____ Driver's Lic# _____

Email Address_____

Employer_____ Work # _____ext_____

Spouse Name: _____ Date of Birth_____

S.S. #_____ Phone#_____

Parent/Guardian

Who is responsible for the patient? _____ Relationship_____

Whom may we thank for referring you to our office? _____

Physician Name_____ PH#_____

Previous Dentist_____ PH#_____

Primary Dental Insurance Co_____ Group #_____

Name of Insured_____ Date of Birth_____

Insured's Soc. Sec/ID #_____

Medical Insurance Co_____ Group #_____

Permission is hereby granted to the Doctor to perform any **necessary** dental work. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the information above.

THE DENTIST HAS RESERVED VALUABLE TIME FOR YOUR APPOINTMENT. PLEASE HONOR YOUR SCHEDULED APPOINTMENTS AND ARRIVE ON TIME. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT *A 24 HR. NOTICE IS REQUIRED,* OTHERWISE A $25 FEE WILL BE CHARGED TO YOUR ACCOUNT.

XXX Signature _____ **Date**_____

Medical Questionnaire

(Please fill out all that apply)

Patient Name_____

Please circle any condition you have a history of:

High Blood Pressure	Heart Trouble	Valve Replacement	Angina
Low Blood Pressure	Heart Murmur	Mitral Valve Prolapse	Asthma
Nervous Disorders	Hay Fever	Radiation Therapy	Leukemia
Diabetes	Rheumatic Fever	Tuberculosis	Kidney Disease
Joint replacement	Hepatitis	Bronchitis	Stroke
AIDS/HIV Positive	Cancer	Epilepsy	Organ Transplant
Thyroid	Herpes	TMJ	Sinus/seasonal allergies
Glaucoma	Arthritis	Venereal Disease	Drug Dependency
Osteoporosis	Pacemaker	Blood Disease	Sleep Apnea

*** Are there any other conditions that may be important to your care? _____

****

Is the Patient under the care of a Physician at this time or within the last 2 years? _____ Yes _____ No

If so, for what _____

****

Have you been hospitalized/had major surgery in the last 2 years? _____ Yes _____ No

If so, for what? _____

****

Have you ever had an **Allergic Reaction** to any medications or materials? _____ Yes _____ No

If so, what medication/materials? _____

****

If female: Are you pregnant or nursing? _____ Yes _____ No

Are you taking birth control or hormones? _____ Yes _____ No

Have you ever been told that you need pre-medication before a dental appointment? _____ Yes _____ No

Are you currently taking any medications? _____ Yes _____ No If so, please list below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke? _____ Yes _____ No Do you chew tobacco? _____ Yes _____ No

Permission is hereby granted to perform any necessary dental work and authorize my insurance company to pay the dentist or dental group all insurance benefits. I also understand that (regardless of insurance status), I am responsible for the balance on this account for any and all services rendered to me or my dependents. I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health or the information above.

XXX Signature_____ Parent or Guardian

Name:_____ **Reason for today's visit:** _____

What is your primary concern you'd like us to address today?

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/ or pain to fix down the road? **YES**____ **NO**____

Do you consider yourself more of a reactive person? Someone who would rather wait to deal with any issues after they develop, even if that means costing you more time, visits, money or pain to fix down the road? **YES**_____ **NO**_____

What do you **value** most in a dental office? **Please circle your answer below.**

Cosmetic- You most value how your teeth look. Want them straight/white. A beautiful smile.

Function- You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side. No food or drink should be off limits to you.

Comfort- You most value NOT being in pain or having any tooth/gum sensitivities.

Longevity- You most value the ability to have your natural teeth forever. You wish to have the work you have done in the chair as long as possible.

Tell us more about that:_____

What is most important **objection/obstacle** you have to visiting a dental office? **Please circle**

Time- Getting appointments to suit your schedule. Not able to take off work. Getting in and out of the office quickly.

Fear- High dental anxiety/fear when visiting the office for treatment. High level of concern about potential pain.

Have NOT had a sense of urgency- Nothing really hurts so haven't seen/need to go to the dentist in years or something has been hurting at some level for a while but been able to live with it.

Budget- Knew I needed a lot of work, didn't have money to address any issues found. Concerned with affordability.

No Trust- Felt you were told you needed treatment you didn't need. Bad previous experience.

Tell us more about that: _____

Do you prefer to pay off your balance over time or in full so nothing is owed? _____

Do you prefer to break your appointments up into smaller visits and schedule out over time or do you prefer to get as much done in one visit? _____

Do you prefer to get any necessary treatment done today, if possible, as getting into the office is a challenge for you? _____

Dental Questionnaire

How do you feel about the appearance of your smile? _____

What would you improve about your smile? _____

Do your gums ever bleed? _____ Yes _____ No When? _____

Are you aware that your gum health can easily place you at risk for a heart attack, stroke, the onset of diabetes, and pregnancy complications? _____ Yes _____ No
Does this info concern you? _____ Yes _____ No

Are you concerned about your health? _____ Yes _____ No Why? _____

Do you experience frequent headaches or migraines presently? _____ Yes _____ No
In the past? _____ Yes _____ No
If so, do you wake up with a headache in the morning? _____ Yes _____ No

Has a headache limited your activities for a day or more in the last three months? _____ Yes _____ No

Are you aware that you clench or grind your teeth? _____ Yes _____ No

If so, when? _____

Do you ever experience tightness, soreness or discomfort in your cheek muscles? _____ Yes _____ No

Do you ever experience soreness or tightness above the shoulders? _____ Yes _____ No

Do you or your partner snore? _____ Yes _____ No

If so, who? _____

Do you feel well rested in the morning? _____ Yes _____ No

Do you routinely feel sleepy during the day? _____ Yes _____ No

If tired, please explain _____

Fabey Dental

HIPAA Privacy Authorization Form

(MUST BE FILLED OUT AND SIGNED)

If you would like some person other than yourself to have access to your medical records and information and allow health care providers to release such information to that person, you must authorize the release of the information in writing. Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person other than yourself to have access to that information now, while you remain competent, you need to complete and sign a HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

Release Information to:

Doctors: ALL_____ Specific _____

Spouse: _____ Phone #_____

Parents/ Guardian: _____ Phone #_____

Child/Children: _____ Phone #_____

Where we can leave messages:

Home#_____ Answering machine_____ Person_____

Work#_____ YES____ NO___

Spouse #_____ YES____NO___

Mobile#_____ YES___ NO___

XXX Signature_____ Date_____

Fabey Dental

Standard of Care

(Must be read and signed)

The standards of care that is practiced here at Fabey Dental is to promote the knowledge, values, and behaviors that support and enhance your oral health with the ultimate goal of improving overall health.

As we are an ADHA Provider we are compliant with the standard that they have provided. These standards can and will be modified based on emerging scientific evidence, ADHA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

We know it is important to you that you are made aware of the Treatment that will be provided for you:

Oral Exams by the Doctor – (Cleaning appointments) 2x year or 1 x year minimum

Bitewing X-rays – once a year, maximum twice a year

Full Mouth Series – every 3-5 years

Medical History – every one year

Oral Cancer Exam – each visit

Periodontal probing exam – once per year, alternating with bitewing X-rays

Fluoride Treatment- as need based on your health as discussed with the Hygienist or Doctor

Standard of care will NOT be dictated by the insurance plans.
We ask that you realize that we don't work for an insurance company. Rather we work 100% for our patients. We know that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

XXX Patients
Signature_____Date_____