RGB Dental

DATE: _____ PATIENT NAME: _____ BIRTHDATE: _____ AGE: ___

MEDICAL HISTORY INFORMATION

1. Are you under a Doctor's care at this time? Yes No If yes, please specify _____
Doctor's Name: _____ Phone number: _____

2. Are you taking any medication at this time including birth control? Yes No
Please list all medications: _____
_____

3. Are you pregnant or nursing at this time? Yes No If yes, specify how many months: _____

4. Do you have, or have had any of the following (please check "yes" or "no")

Alcoholism	yes__ no__	Epilepsy	yes__ no__	Liver problems	yes__ no__
Artificial heart valve	yes__ no__	Fainting	yes__ no__	Low blood pressure	yes__ no__
AIDS/HIV+	yes__ no__	Glaucoma	yes__ no__	Lung disease	yes__ no__
Anemia	yes__ no__	Heart attack	yes__ no__	Pacemaker	yes__ no__
Angina	yes__ no__	Heart surgery	yes__ no__	Bisphosphonates	yes__ no__
Arthritis	yes__ no__	Heart murmur	yes__ no__	Psychiatric care	yes__ no__
Asthma	yes__ no__	Heart problems	yes__ no__	Recreational drugs	yes__ no__
Bleeding problems	yes__ no__	Hepatitis	yes__ no__	Rheumatic fever	yes__ no__
Cancer	yes__ no__	High blood pressure	yes__ no__	Sexually transmitted	
Chemo/rad	yes__ no__	Implants/surgical		disease	yes__ no__
Cosmetic surgery	yes__ no__	screws	yes__ no__	Sinus trouble	yes__ no__
Diabetes	yes__ no__	Jaundice	yes__ no__	Smoking tobacco	yes__ no__
Dizzy spells	yes__ no__	Joint prosthesis	yes__ no__	Stroke	yes__ no__
Drug addiction	yes__ no__	Kidney disease	yes__ no__	Thyroid problems	yes__ no__
Emphysema	yes__ no__	Latex allergy	yes__ no__	Tuberculosis	yes__ no__

C.Diff (Clostridium difficile) yes__ no__

5. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? yes__ no__
Please specify _____

6. Are there any health problems of which we should be advised? yes__ no__ If yes, please specify _____
_____

DENTAL HISTORY FORM

1. Are there any conditions of which we should be aware? yes__ no__ If yes, please specify _____
_____

2. Why are you here today? Check-up _____ Cleaning _____ Toothache _____ Other _____

3. When did you last visit a dentist? _____

4. Was treatment performed? yes__ no__ Was treatment completed? yes__ no__

5. Did you have a cleaning? yes__ no__ When were you last dental x-rays? _____

6. Have you ever had prolonged bleeding after an extraction? yes__ no__ If yes, please specify _____
_____

7. Have you ever had any problems with past dental treatment? yes__ no__ If yes, please specify _____
_____

8. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open? yes__ no__ I f yes, please specify _____

9. Have you ever been diagnosed or treated for TMJ, clenching or grinding? yes__ no__
10. Do your gums bleed easily? yes__ no__ 11. Do you feel you have bad breath? yes__ no__
12. Are your teeth sensitive to hot and cold? yes__ no__
13. Are there any cosmetic changes you would like to have done on your teeth? yes__ no__ If yes, please specify:
_____

14. How did you hear about our office: Patient?, Name _____ Phonebook _____
Doctor?, Name _____ Other _____

RGB Dental

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of X-rays and oral examination.

I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Consent: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment use medication and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine. Payment is due at the time services are rendered, unless previous arrangements have been made. I further authorize Doctor to investigate my credit report if and when credit is to be extended by him. Unpaid balances over 60 days are subject to a 1.5% monthly service charge. I understand that I am financially responsible for any charges not covered by or paid for by my insurance plan for whatever reasons.

I have had the option to read, understand & have been offered a copy of the HIPAA regulations and the dental materials fact sheet.

PATIENT SIGNATURE _____Date _____

Doctor's notes**:**

_____

_____

Doctor Signature _____ Date_____

As your dental health provider, it is our desire to provide you with the best dental care possible. In an effort to continually improve the value of our services, we would like to ask you to please take a moment to fill out the questionnaire below prior to seeing the doctor. For denture wearers, please answer where applicable.

	Yes	No
1. Are you satisfied with the appearance of your smile?	___	___
2. Would you like whiter teeth (i.e., teeth whitening procedure)?	___	___
3. Do you have spaces between your teeth you want closed?	___	___
4. Do you have dark visible fillings you want replaced?	___	___
5. Do your gums feel unhealthy?	___	___
6. Are you involved in any sports requiring a mouth guard?	___	___
7. Do you clench your teeth?	___	___
8. Do you snore or have sleep apnea?	___	___
9. If you wear a partial, are you unhappy with visible metal clasps?	___	___
10. If you have crowded teeth, would you like them straightened:	___	___

Thank you for completing this form, and again, thank you for choosing us.

Recall review:
1. Patient's signature _____Dr's signature _____ Date _____
2. Patient's signature _____Dr's signature _____ Date _____
3. Patient's signature _____Dr's signature _____ Date _____

RGB Dental

Patient Information

Name _____
(Last) (First)

Address _____Zip_____

Phone: H _____ W _____

Email _____

SS # _____

Date of birth _____

Resp.Party(if different than patient)

Name _____
(Last) (First)

Address _____Zip_____

Phone: H _____ W _____

Email _____

SS # _____

Date of birth _____

Insured's Information

Relationship to patient _____

Employer _____

Primary Ins. Carrier _____ Secondary Ins. Carrier _____
(Name) (Name)

Phone # _____ Phone # _____

Group # _____ Subscriber ID#_____ Group # _____ Subscriber ID#_____

Person to contact for emergency

Name _____ Address _____

City _____ State _____ Telephone # _____

Spouse Name _____ Telephone # _____

Authorization

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered or paid for by my insurance plan for whatever reason.
2. I authorize my insurance company to pay to the dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
3. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize release of any information relating to any dental claim(s).
4. I understand that it is my responsibility to have the correct insurance information. I understand that I need to inform RGB Dental of any changes to my insurance. I understand that RGB Dental will submit claims as a ***courtesy*** to me, again provided that I give the complete information necessary for these claims. I agree to pay my co-payment on the day of service. I understand that it is "I" who has the contract with the insurance company and RGB Dental merely submits treatment done. I understand that I may have treatment pre-authorized.

Signature _____ **Date** _____

RGB Dental

Patient Name _____

DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN:

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

REMOVAL OF TEETH:

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the Dentist to remove the recommended teeth and any others necessary due to a change in treatment plan. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time (days, months or in rare cases, permanently) or fractured jaw. I understand I may need further treatment by a specialist of even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

CROWNS AND BRIDGES:

I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily, and I must be careful to ensure that they are dept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit size and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crown or bridge it may not fit properly and I will be responsible for any lab fees incurred if a remake becomes necessary.

DENTURES-COMPLETE OR PARTIAL:

I realize full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape fit, size, placement and color) will be the “teeth in wax” try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines in not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL):

I realize there is no guarantee that root canal therapy will save my tooth and complications may occur (such as pain or infection) from the treatment. I further realize that occasionally root canal filling material may extend through the root or it may not be possible to completely fill the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Signature: _____ Date: _____

Doctor: _____ Date: _____