FLOSS

FAMILY DENTAL & SURGICAL CENTER

5760 S. 86th Dr., Suite 2
Lincoln, NE 68526
Phone: 402.484.5760
www.flosslincoln.com

Welcome!

Our goal is to help you achieve and maintain your oral health and a smile you are proud to show. Please fill out the forms below. We want to make sure that we are well informed about your medical history, current medictions, and any other factor that might affect your dental treatment.

ABOUT YOU

Today's Date: _____ Referred by: _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

Spouse's Name: _____

Spouse's Birthdate: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

When and where are the best times to reach you? _____

Other Family Members Seen by Us: _____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Person Responsible for Account (if other than yourself): _____

_____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

ACKNOWLEDGMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in any insurance or medical status.

Signature: _____

Date: _____

I understand that I will be required to pay my estimated portion of Floss Family Dental & Surgical Center fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement. See additional financial policies on Page 3.

Signature: _____

Date: _____

MEDICAL HISTORY

Do you have a primary physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently taking any prescription medications? **Yes** **No** **Please List Medications with Correlating Diagnosis:** _____

_____

Hospitalized for any reason: **Yes** **No** Please explain: _____

For Women: Are you currently taking any oral contraceptives? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? _____ For how long? _____

ALLERGIES – Circle any and all of the following to which you are allergic:

Aspirin • Barbituates/SleepingPills • Codeine • DentalAnesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • PenicillinTetracycline • Vicodin

Please list any other medications and/or materials to which you think you are allergic: _____

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MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? Circle "Yes"

Abnormal Bleeding	**Yes**	**No**	Frequent Headaches	**Yes**	**No**	Pacemaker	**Yes**	**No**
Alcohol or Drug Abuse	**Yes**	**No**	Glaucoma	**Yes**	**No**	Psychiatric Problems	**Yes**	**No**
Anemia	**Yes**	**No**	Hay Fever	**Yes**	**No**	Radiation Treatment	**Yes**	**No**
Arthritis	**Yes**	**No**	Heart Attack	**Yes**	**No**	Rheumatic/Scarlet Fever	**Yes**	**No**
Artificial Bones/Joints/Valves	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Seizures	**Yes**	**No**
Asthma	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Shingles	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Hemophilia	**Yes**	**No**	Sickle Cell Disease/Traits	**Yes**	**No**
Cancer/Chemotherapy	**Yes**	**No**	Hepatitis	**Yes**	**No**	Sinus Problems	**Yes**	**No**
Colitis	**Yes**	**No**	Herpes/Fever Blisters	**Yes**	**No**	Stroke	**Yes**	**No**
Congenital Heart Disease	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Diabetes	**Yes**	**No**	HIV or AIDS	**Yes**	**No**	Tuberculosis/TB	**Yes**	**No**
Difficulty Breathing	**Yes**	**No**	Kidney Problems	**Yes**	**No**	Ulcers	**Yes**	**No**
Emphysema	**Yes**	**No**	Liver Disease	**Yes**	**No**	Venereal Disease	**Yes**	**No**
Epilepsy	**Yes**	**No**	Low Blood Pressure	**Yes**	**No**			
Fainting Spells	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**			

Please explain any serious medical conditions you have ever had: _____

_____

DENTAL HISTORY

Previous Dentist: _____ Phone:_____ Last Visit Date:_____

Date of Last Cleaning:_____ Date of Last Dental X-rays:_____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath	**Yes**	**No**	Grinding or Clenching of Teeth	**Yes**	**No**	Sensitivity to Cold	**Yes**	**No**
Bleeding Gums	**Yes**	**No**	Gums Swollen or Tender	**Yes**	**No**	Sensitivity to Heat	**Yes**	**No**
Blisters on Lips or in Mouth	**Yes**	**No**	Jaw Pain	**Yes**	**No**	Sensitivity to Sweets or Sour	**Yes**	**No**
Broken Fillings	**Yes**	**No**	Jaw Fatigue	**Yes**	**No**	Sensitivity When Chewing	**Yes**	**No**
Burning Sensation on Tongue	**Yes**	**No**	Lip or Cheek Biting	**Yes**	**No**	Sores or Growths in Mouth	**Yes**	**No**
Chew on Only One Side	**Yes**	**No**	Loose Teeth	**Yes**	**No**	Do You Wear a Night Guard	**Yes**	**No**
Clenching of Teeth	**Yes**	**No**	Mouth Breathing	**Yes**	**No**	History of Difficult Extractions	**Yes**	**No**
Clicking or Popping of Jaw	**Yes**	**No**	Orthodontic Treatment	**Yes**	**No**	Prolonged Bleeding	**Yes**	**No**
Dry Mouth	**Yes**	**No**	Pain Around Ear	**Yes**	**No**	Do You Wear Dentures or	**Yes**	**No**
Food Collection Between Teeth	**Yes**	**No**	Pain When Brushing	**Yes**	**No**	Partials. If yes, date placed	_____	
Foreign Objects in Mouth			Periodontal Treatment	**Yes**	**No**			

Have you ever had a serious/difficult problem with any previous dental work? **Yes** **No**

How would you classify your current dental health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? 1 2 3 4 5 6 7 8 9 10

Would you like whiter teeth? **Yes** **No**

Do you feel anxiety about dental treatment? **Yes** **No**

On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? 1 2 3 4 5 6 7 8 9 10

On average, how many times a day do you brush? _____ ____ How many times a week do you floss? _____

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SLEEP HISTORY

Have you ever been told that you need to wear a CPAP for sleep? **Yes** **No**

Is it easy for you to get to sleep? **Yes** **No**

Do you wake often? **Yes** **No**

Do you feel rested in the morning when you wake up? **Yes** **No**

What is your sleeping position? **Back** **Side** **Stomach** **Varies**

AUTHORIZATION & RELEASE OF INFORMATION

- I authorize Floss Family Dental & Surgical Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent(s) during the period of such dental care to the third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to Floss Family Dental & Surgical Center` insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for me or for my dependent(s).

Signature of Patient (or Parent/Guardian of Patient) Date

PAYMENT OPTIONS

For your convenience, we offer the following payment options. Please circle the option you prefer below:

Cash **Personal Check** **VISA** **MasterCard** **Care Credit** **I wish to discuss the financial policies**

AUTHORIZATION & RELEASE FOR GENERAL RISKS ASSOCIATED WITH DENTAL TREATMENT

Thank you for choosing Floss Family Dental & Surgical Center for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment but should still be considered when making treatment decisions. **Benefits of dental treatment include:** relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. **Common risks associated with virtually any dental procedure include:**

- **Allergic reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
- **Long-term numbness (parasthesia).** Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary or, in rare instances, permanent numbness.
- **Muscle or joint tenderness:** Holding one's mouth open for prolonged periods of time, such as during dental treatment can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- **Sensitivity in teeth or gums, infection, or bleeding.**
- **Swallowing or inhaling small objects.**

We follow procedural guidelines that most often lead to clinical success but, as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regards to any and all dental procedures that are recommended to you for yourself or for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

Signature of Patient (or Parent/Guardian of Patient) Date

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Page 4 – Thank You!

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 dental treatment and follow-up care among the multiple health care providers and professionals who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal health care operations, including quality assessments and physician certification.

I acknowledge having received, read, and understood the *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that Floss Family Dental & Surgical Center have the right to change the *Notice of Privacy Practices* from time to time, and that I may contact Floss Family Dental & Surgical Center at any time at the address above to obtain a current copy of the *Notice 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 that Floss Family Dental & Surgical Center are not required to agree to my requested restrictions, but that formally agreed upon restrictions are legally binding.

Patient Name: _____

Patient's Parent/Guardian Name (if applicable): _____

Signature of Patient (or Parent/Guardian of Patient): _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's/patient guardian's signature to acknowledge receipt of the *Notice of Privacy Practices* but was unable to do so as documented below:

_____

_____

_____

_____ _____
Date