Focus Dental Group

Patient Information

❒ Male ❒ Female ❒ Married ❒ Single ❒ Minor

Name _____ Preferred _____

Address _____ City, State, Zip _____

Date of Birth _____ Social Security #_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____

Would you like to confirm future appointments through email? ❒ Yes ❒ No

Whom may we thank for referring you to us, or how did you discover our office?_____

In case of an emergency, please list a contact:

Name_____ Phone_____

Insurance Information

Primary	**Secondary**
Policy Holder _____	Policy Holder _____
Date of Birth _____	Date of Birth _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Insurance Co. _____	Insurance Co. _____

Assignment of Insurance Benefit: I hereby authorize my insurance benefits to be paid directly to Focus Dental Group. I am responsible for services not covered. I authorize release of any dental information or x-rays necessary to process any claim.

Agreement for Extension of Credit

In accordance with the federal Truth-in Lending Act, please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the responsible party agrees to:

-Pay in full each time services are rendered. We accept cash, check and major credit cards.

-Pay 2% per month on any unpaid balance that extends over 30 days, with a minimum charge of $2.00.

-Authorize a credit report to be obtained if deemed necessary.

-A $50.00 charge for appointments missed or cancelled without a 48 hour notice, and understand that my insurance company will not pay that charge.

I agree to pay the remaining balance plus all collection/court costs and fees (a minimum of 40% of the balance) if a delinquent balance is placed with a collection agency or attorney.

Please choose your preferred method of payment: ❒ Cash ❒ Check ❒ Credit/Debit Card ❒ CareCredit/Outside Funding

Sign _____ Date _____

Focus Dental Medical History

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1.	Do you consider yourself to be in good health?	YES	NO
2.	Are you now or have you been under a physician's care within the past year?	YES	NO
	If Yes, specify condition being treated:_____		
3.	Please list any medications you are currently taking:_____		
	_____		
4.	Do you have or have you ever had any heart or blood problems, including a heart murmur?	YES	NO
5.	Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	YES	NO
6.	Do you have or have you ever had high blood pressure?	YES	NO
7.	Do you bleed or bruise easily?	YES	NO
8.	Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
9.	Have you ever had hepatitis A, B, or C or liver disease? (Please circle)	YES	NO
10.	Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; latex allergy_____; heart attack_____; kidney disease_____; immune system disorders_____; other disease_____?		
11.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other _____	YES	NO
12.	Are you subject to fainting?	YES	NO
13.	Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
14.	Have you ever been told you snore	YES	NO
15.	Do you have any other allergies? If Yes, please describe:_____	YES	NO
16.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
17.	Have you ever received counseling for use of alcohol and/or prescription drugs?	YES	NO
18.	Women: Are you pregnant?	YES	NO
19.	Do you have or have you ever had bleeding or sensitive gums?	YES	NO
20.	Have you ever taken appetite suppressants?	YES	NO
	If Yes, have you seen your physician or cardiologist for a cardiac evaluation?	YES	NO
21.	Have you ever used or are you now using tobacco or alcohol?	YES	NO
22.	Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?	YES	NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ **Date**_____
(Patient, legal guardian)

Signature_____ **Date**_____
(Health history reviewed and updated)

Signature_____ **Date**_____
(Health history reviewed and updated)

Signature_____ **Date**_____
(Health history reviewed and updated)

Focus Dental Group

I authorize affiliated doctors and/or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. Including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments that could possibly be used.

I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include, but are not limited to; bruising, hematoma, cardiac stimulation, temporary numbness and rarely, permanent numbness and muscle soreness. I do voluntarily assume any and all possible risks associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

_____ _____

Signature Date

Focus Dental Group

HIPAA PRIVACY LAW
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's notice of privacy practices.

Date

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement

_____ _____

Signature Date

_____ _____

Witness Date

LASER BACTERIAL REDUCTION

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is a growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We now know that Periodontal Disease is a bacterial infection in the pockets around teeth. As such, we **now** not only treat Perio with removal of mechanical irritants and diseased tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patients have their teeth decontaminated prior to cleaning appointments for three major reasons:

1. **To reduce or eliminate bacteremias:** During the normal cleaning process, most patients will have some areas that may bleed, this allows bacteria that are present in all of our mouths to flood into the bloodstream and sometimes settle in weakened areas of our body such as a damaged heart valve or artificial knee or hip etc. We pre-medicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes etc. Needless to say anything that we can do to reduce or eliminate these bacteremias is a **positive** for our patients.
2. **To prevent cross contamination** of infections in one area of your mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.
3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction or loss of attachment around your teeth.

The laser decontamination process is **painless** and normally takes about 5-10 minutes. We **highly** recommend that you take advantage of this service as part of your routine cleaning.

Laser decontamination is $35 and is **NOT** covered by insurance. Unfortunately, insurance coverage is almost always behind the leading edge in high tech health care.

Please ask our hygienist if you have any questions regarding this treatment. Please sign below if it's okay for us to perform this service for you today.

_____	_____	_____
Yes	Signature	Date
_____	_____	_____
No	I understand the benefits of laser bacterial reduction, but choose not to do it today.	