# Tarrytown Dental

2630 Exposition Blvd. G01 • Austin, Texas 78703 • 512.477.5100 • fax:512.477.8820

www.AustinDDS.com www.TarrytownDental.com

## ☐ Patient Information

Patient's Name_____ Date_____
Last First MI

Preferred/Nick Name_____ ☐Male ☐Female ☐Married ☐Single ☐Minor

Address_____City _____ State _____Zip_____

Social Security # _can be filled out in office____Birth Date_____ E-mail_____

Phone (Home) _____ (Work) _____ Ext_____Cell Phone_____

Employer Name_____ Occupation_____

If Full Time Student, School Name_____Grade_____

How do you prefer to be contacted for appointment confirmation?_____

Emergency Contact: Name: _____ Phone: _____

How did you hear about our office? ☐Another patient ☐Internet ☐Insurance Company ☐Dental Office ☐Mailing

☐Yellow Pages ☐Work ☐Other_____

Name of person or office referring you to our practice_____

## ☐ Person Responsible for Payment (if other than patient) ☐Guardian ☐Spouse ☐Father ☐Mother

Name: _____ ☐Male ☐Female ☐Married ☐Single

Social Security # _can be filled out in office_____Birth Date_____ Driver's License #:_____

E-Mail_____

Phone (Home)_____ (Work)_____ Ext:_____ Cell Phone_____

Address_____City_____ State_____ Zip_____

## ☐ Insurance – Primary

Name_____
Last First MI

Relation to Patient_____ Birth Date_____

Street _____

City, State, Zip_____

Tel. (____)_____S.S.#_____

Alt. I.D.#: _____

Employer_____

Bus. Phone _____

Ins. Co. Name _____

Address _____

_____Tel. _____

Group #_____Group Name_____

## ☐ Insurance – Secondary

Name_____
Last First MI

Relation to Patient_____ Birth Date_____

Street _____

City, State, Zip_____

Tel. (____)_____S.S.#_____

Alt. I.D.#: _____

Employer_____

Bus. Phone _____

Ins. Co. Name _____

Address _____

_____Tel. _____

Group #_____Group Name_____

# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury _____ | ☐ | ☐ |
| 2. an allergic reaction to | | |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulpha | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ other _____ | | |
| 3. heart problems, or cardiac stent within the last six months __ | ☐ | ☐ |
| 4. history of infective endocarditis _____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator _____ | ☐ | ☐ |
| 7. artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. rheumatic or scarlet fever _____ | ☐ | ☐ |
| 9. high or low blood pressure _____ | ☐ | ☐ |
| 10. a stroke (taking blood thinners) _____ | ☐ | ☐ |
| 11. anemia or other blood disorder _____ | ☐ | ☐ |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | ☐ | ☐ |
| 13. emphysema, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis _____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice _____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c = _____) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders (i.e. gastric reflux) _____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis _____ | ☐ | ☐ |
| 28. glaucoma _____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder) _____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth _____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever _____ | ☐ | ☐ |
| 36. venereal disease _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth _____ | ☐ | ☐ |
| 40. radiation therapy _____ | ☐ | ☐ |
| 41. chemotherapy _____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment _____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / drug dependency _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your general health _____ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements _____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. subject to frequent headaches _____ | ☐ | ☐ |
| 52. a smoker or smoked previously _____ | ☐ | ☐ |
| 53. considered a touchy person _____ | ☐ | ☐ |
| 54. often unhappy or depressed _____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - prostate disorders _____ | ☐ | ☐ |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Ask for an additional sheet if you are taking more than 6 medications

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

# DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** _____

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:** **YES** **NO**

## PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

## BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

## TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

## GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _ _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

# INFORMED CONSENT

***The Medical Consent Law requires doctors to advise patients of the general nature of treatment procedures, the acceptable treatment alternatives, and the risks inherent with the dental procedure. This disclosure is not meant to alarm you; it is simply an effort to inform you so you may give or withhold your consent to a procedure. Please ask about anything you do not understand.***

*Anesthetic, sedation, or medications:*

- *Sedative/ Medication Use:* I understand that sedatives/medications are optional and can be used if I choose that I need help in relaxing during a dental procedure. Taking sedatives for relaxation or medication for comfort may cause disorientation, confusion, or prolonged drowsiness after dental work as well as cardiovascular & respiratory responses which may require treatment. I understand that I must have a driver to and from the dental appointment if I use sedatives or medications. Alternatives include no anesthetic, sedation, or medication.
- *Potential risks:* Possible complications to local anesthetic or sedation may include redness, bruising, pain, swelling, itching, vomiting, rapid heartbeat, reoccurrence of cold sores if you are already prone to getting ulcers, fainting, broken instruments, nerve damage that causes numbness, altered sensations in the teeth, gums, lip, chin, and tongue (including possible altered taste) which can be transient but on infrequent occasions may be permanent. Occasionally a quick feeling of "shock" can occur when administering local anesthetic. Local anesthetic may keep you numb for several hours or longer. Possible adverse reactions to anesthetics, nitrous oxide (laughing gas), or medications may lead to hospitalization, treatment by a specialist, allergic reactions, or advanced medical conditions.

*Fillings / Crowns / Veneers*

I understand that fillings/crowns/veneers are attempts to save, strengthen, or improve the esthetics of teeth that have defects. Although fillings and crowns have a very high degree of success (about 95%) they cannot be guaranteed. Reduction of tooth structure may be necessary prior to repairing the tooth. Depending on your needs alternatives may be available:

- Alternatives to having crowns/veneers can include: no treatment, fillings, extractions, dentures, partial dentures, whitening teeth instead of placing veneers, orthodontic treatment to improve your alignment or implants. No treatment or other alternatives listed may have a negative effect to the overall dental health.
- Alternatives to having fillings can include: no treatment, extractions, dentures, or crowns/inlays. No treatment or other alternatives listed may have a negative effect to the overall dental health.

There are certain inherent and potential risks with any procedure. Fillings, Crowns, and Veneers have risk that may include, but are not limited to:

- Temperature or biting sensitivity. Teeth may develop a condition known as pulpitis. The tooth or teeth may have been traumatized from removal of a large cavity, previous cracks, or other causes. It may be necessary to do root canal treatments in these teeth. Teeth with decay or fractures that extend below the gum line may require crown lengthening. Infrequently, the tooth (teeth) may abscess or otherwise not heal which may require root canal treatment, root surgery, crown lengthening or possibly extraction at an additional expense to the patient.
- *Breakage or Chipping*. Many factors could contribute to this situation such as chewing excessively hard materials, changes in biting forces, traumatic blows to the mouth, etc. Unobservable cracks may develop in crowns from these causes, but the crowns may not actually break until chewing soft foods or possibly for no apparent reason. In some cases the tooth structure under the crown, veneer, or filling may break or get recurrent decay.
- In limited situations, muscle soreness, restricted mouth opening, and tenderness of the jaw joints (TMJ) may persist for indeterminable periods of time following treatment and may require additional treatment. Stretching of the corners of the mouth may result in cracking or bruising.
- *Esthetics or appearance:* All efforts will be made to make fillings, crowns, or bridgework match your esthetic expectations but patients should be aware that matching one, two, or three teeth with the rest of the teeth is the hardest thing to do in dentistry. A perfect match cannot be guaranteed but the doctor, the lab, and the team achieve excellent esthetic results most of the time.
- *Longevity:* There are many variables that determine "how long" a filling, crown/veneer, or bridge can be expected to last. Among these are general health, oral hygiene, regular dental checkups/cleanings, diet, oral habits (ice chewing, hard candies, grinding or clinching, etc.), trauma, etc. Because of this, no guarantees can be made or assumed about the longevity of a restoration. Permanent restoration may need to be replaced in the future.
- *If a temporary restoration is placed, it may remain for more than 2 weeks. You must promptly return to have the final restoration or risk damage to the tooth.*
- Failure to complete recommended treatment promptly may eventually lead to the tooth requiring additional treatment including root canal or extraction.

Dental Cleaning, Prophylaxis, Periodontal Maintenance, Gross Debridement, SCRP:

*I understand depending on the type of cleaning I have: plaque, calculus, diseased soft and hard tissue may be removed from around my teeth. I understand that risk may include increased tooth sensitivity, additional gum recession, loosening of teeth, pain, bruising, bleeding gums, TMJ dysfunction and infection. I also understand that dental restorations, retainers, and compromised tooth structure may chip or debond during treatment requiring repair. If a repair is needed due to previously defective restoration or tooth then this will be repaired at an additional expense to the patient. I understand that if my periodontal health is not at a healthy level then there is a risk of tooth loss, bone loss, and infection. I understand that not following recommended treatment may cause tooth/bone loss and infection. I further understand no guarantee is made relative to the results that may be obtained in my periodontal health following treatment. Alternatives may include no periodontal treatment. No treatment may have a negative risk to the overall dental health.*

*All dentist are prohibited from making certain guarantees (State of Texas Rule 108.52)*

I understand that no specific results can be assured, warranted or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I authorize. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

**SIGNING THIS FORM ACKNOWLEDGES I HAVE RECEIVED AND UNDERSTAND THIS FORM .**

>_____ Date:_____ Relationship to Patient: _____

Signature of patient, parent or legal representative.

# FINANCIAL POLICY & AUTHORIZATIONS

• As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment.

• All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed. We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we work with outside financing, which offers short and long term programs designed to meet your treatment plan needs on approved credit. Ask for details.

• If you have a Dental Plan please know that it is designed to help you pay for a portion of the cost of your dental care. Therefore, patients who have dental insurance should understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will prepare insurance forms and assist in obtaining payment from your insurance company on your behalf and will credit any such payments to your account. Please understand our dental office cannot render services on the assumption that our charges will be paid by your insurance company.

• Insurance eligibility and benefits quoted are not a guarantee, they are subject to change. We will provide you with an estimate of your co-payments and deductible based on your insurance coverage which is payable at the time of your visit. This ESTIMATE IS NOT A GUARANTEE of the final amount of benefits to be paid by your insurance company. The final amount of benefits to be paid will be determined by your insurance company only after they receive the dental claim. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for all of your restorative dental care. It is only meant to assist you.

• The amount your plan pays is determined by the agreement negotiated by your employer with the insurer and by how much your employer contributes to the plan.

• As a service to you, we will submit your dental claims to your insurance company. Keep in mind that dental plans are designed to share in the cost of your dental care, not to completely pay for those costs.

• I authorize the Dental Office to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I authorize the Doctor to perform dental treatment, medication, and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance that may be necessary for proper dental care.

• I authorize the release of information including the diagnosis and records of treatment or examination rendered to either myself or a dependent to my insurance company and/or healthcare practitioner. I authorize and request that my insurance company pay directly to the doctor insurance benefits otherwise payable to me.

• I further agree to pay for all services rendered regardless of anticipated insurance benefits within 30 days of the date of service and agree to pay all reasonable attorney fees or collection costs associated with non-payment of an account balance. I grant my permission to be contacted to discuss my statements or my treatment.

• A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of anticipated insurance payments.

• Cancellation Policy: Our office requires a 24 hour notice for cancellation of a dental appointment. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $45.00/hour cancellation fee.

**• I have read and understand the above Financial Policy and Authorizations.**
**• I acknowledge receipt of this office's Notice of Privacy Practices.**

>_____ Date:_____ Relationship to Patient: _____

Signature of patient, parent or legal representative.