PATIENT INFORMATION (CONFIDENTIAL) PLEASE PRINT

RAVEN Dental
Peter T. Raven, DDS LLC

Patient First Name / Middle Initial / Last Name Preferred Name

Home Address Street/City/State/Zip Phone

____Male ____Female Marital Status: ___Single ___Married ___Divorced ___Widowed ___Child

Date of Birth Social Security Number Email Address

Employment Status: ___F/T ___P/T ___Retired ___Student Employer

(May we call you at work?) ___Yes ___No

Spouse (or Parent/Guardian Name, if Minor) Address/Phone

Emergency Contact Name and Phone (OTHER THAN SPOUSE) Who may we thank for referring you to our practice?

RESPONSIBLE PARTY

Person Responsible for the Account Relationship to Patient Address

Cell Phone Home Phone Work Phone

INSURANCE INFORMATION - *Primary Insurance*

Name of Policy Holder Relationship to Patient Social Security Number

Date of Birth Employer Employer Address

Insurance Company Group Number ID Number

Secondary Insurance

Name of Policy Holder Relationship to Patient Social Security Number

Date of Birth Employer Employer Address

Insurance Company Group Number ID Number

INSURANCE AGREEMENT AND RELEASE:

- I certify that the above insurance information is correct and in force.
- I understand that filing of insurance claims is my responsibility and is provided as a service to me, and that any agreement for dental coverage is between my insurance company and myself.
- I understand my portion may be more if my insurance company does not pay the anticipated amount.
- I understand that services are rendered independent of insurance reimbursement.
- I hereby authorize Raven Dental to release all information necessary to secure the payment of insurance benefits.
- I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party **Date**

Name:_____

Preferred Contact # _____

RAVEN Dental
Peter T. Raven, DDS LLC

Dental History ~ Circle Yes or No if you have had any of the following in the *past 12 months*:

Yes	No	Bad Breath	Yes	No	Grinding teeth	Yes	No	Sensitivity to Hot/Cold
Yes	No	Bleeding gums	Yes	No	Loose teeth	Yes	No	Sensitivity to Sweets
Yes	No	Clicking/Popping jaw	Yes	No	Periodontal disease	Yes	No	Sensitivity when biting
Yes	No	Food collection in teeth	Yes	No	Dry Mouth	Yes	No	Sores/growths in mouth

If you could change your smile, what would you change?

___ Remove Unsightly fillings ___ Straighten teeth___ Change shape of teeth ___ Close gap between teeth ___ Replace missing teeth

___ Whitening ___ Make teeth the same color ___ Other _____

_____ _____

Reason for today's visit Previous Dentist Name/Date of last exam, x-rays

Medical History ~ Circle Yes or No if you have *EVER* had any of the following:

Yes	No	Arthritis	Yes	No	Stomach/Intestinal Disease	Yes	No	Thyroid disease
Yes	No	Artificial Heart Valves	Yes	No	Ulcer	Yes	No	Excessive Bleeding/Hemophilia
Yes	No	Endocarditis	Yes	No	Stroke/Mini Stroke	Yes	No	Hepatitis A,B,C
Yes	No	Heart Murmur	Yes	No	Epilepsy/Seizures	Yes	No	HIV Positive
Yes	No	Heart Attack	Yes	No	Fainting	Yes	No	Osteoporosis
Yes	No	Irregular Heartbeat	Yes	No	Asthma/Breathing Problems	Yes	No	Artificial Joints
Yes	No	Pacemaker	Yes	No	Respiratory Disease	Yes	No	Cancer
Yes	No	High or Low Blood Pressure	Yes	No	Emphysema	Yes	No	Chemotherapy
Yes	No	Diabetes, Type I or II	Yes	No	Kidney or Liver Disease	Yes	No	Radiation

List any serious illness/operation in the last 5 years:_____

Currently being treated for:_____

MEDICATION (PRESCRIPTION & NON-PRESCRIPTION)

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

ALLERGIES/PHARMACY

___Aspirin ___Codeine ___Latex ___Sulfa
___Penicillin ___None ___Other:

_____

_____

Preferred Pharmacy:

_____

AUTHORIZATION AND CONSENT

- I certify that the questions on this form have been accurately answered. I understand that I am responsible to inform Raven Dental of any changes in my medical status.
- I understand that payment is due at the time services are rendered, unless PRIOR arrangements have been made.
- We accept Cash, Personal Check, Visa/MasterCard/Discover & Care Credit. A 1.5% monthly service charge will be applied to all balances over 90 days.
- Any patient clinical photos may be used for educational or promotional materials.
- I authorize Raven Dental to perform dental treatment on the above patient.

Appointments are reserved exclusively for you, 48 hour notice is required if you are unable to keep an appointment.

_____ _____

Signature of Patient or Authorized Responsible Party **Date**

Please take a few minutes to answer the following questions before your first appointment with us. Your candid answers will help us better understand your concerns and expectations.

1. What prompted you to contact our office for an appointment? _____

_____
___

2. Does dental treatment make you nervous? __No __Slightly __Moderately __Extremely

3. Have you ever had any serious trouble associated with previous dentistry? ___No ___Yes

4. Do use the following?

Toothbrush ___Yes ___No How often? _____

Dental Floss ___Yes ___No How often? _____

Other ___Yes ___No What & how often? _____

5. Do you have or have you ever had any of the following?

Orthodontic Treatment?	___Yes ___No	Loose Teeth?	___Yes ___No
Clicking/Popping jaw?	___Yes ___No	Sensitivity to hot/cold?	___Yes ___No
Difficulty opening/closing jaw?	___Yes ___No	Sensitivity to chewing?	___Yes ___No
Clenching or grinding?	___Yes ___No	Bleeding or sore gums?	___Yes ___No

Treatment for periodontal disease (gum disease)? ___Yes ___No

6. On a scale of 1 to 10 (1 being terrible and 10 being perfect)

How healthy do you think your mouth is? _____

7. On a scale of 1 to 10 (1 being terrible and 10 being perfect)

How healthy would you like your mouth to be? _____

8. Are you happy with the appearance of your teeth? ___Yes ___No

If you answered “NO” and we could wave a magic wand and instantly change anything about the appearance of your teeth, what would it be? _____

9. Do you expect to keep your teeth for the rest of your life? ___Yes ___No

10. Are there any questions about dentistry and your health that you have never had answered adequately? _____

Name: _____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- ~ Obtain payment from third-party payers.
- ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time during regular business hours 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient: self_____ parent_____ guardian_____ other_____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date_____ Initials_____ Reason_____