PATIENT INFORMATION (CONFIDENTIAL) PLEASE PRINT

Patient First Name / Middle Initial / Last Name _____ Preferred Name _____

Home Address: Street/City/State/Zip _____ Phone _____

____Male ____Female Marital Status: ___Single ___Married ___Child ___Other

Date of Birth _____ Social Security Number _____ Who may we Thank for Referring you? _____

Employment Status: ___Full Time ___Part Time ___Retired ___Student

Employer Name _____

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

Emergency Contact Name (OTHER THAN SPOUSE) _____ Emergency Contact Phone _____

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

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 _____

Name:_____ **Date of Birth:**_____

Preferred Contact # _____ **Email:**_____

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?

___ Teeth Whitening ___ Straighten teeth ___ Change shape of teeth

___ Replace missing teeth ___ Replace old fillings Other _____

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 TAKING:

_____

_____

_____

_____

_____

ALLERGIES/PHARMACY (Circle all that apply)

_ NONE ___Codeine ___Latex

__ Sulfa ___Penicillin ___Asprin

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 authorize Raven Dental to use any patient clinical photos for educational or promotional materials.
I authorize Raven Dental to perform dental treatment on the above patient.

_____ _____

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

Financial Agreement

Payment for service is due at the time of treatment unless prior arrangements have been made. For your convenience, we accept personal checks, Visa, Mastercard, Discover, Care Credit and cash. A 5% savings is offered for payment in full at the time of treatment for patients WITHOUT dental insurance and not using CareCredit.

For those with insurance, our office will file insurance claims as a service to you. We do our best to estimate your insurance benefit. Estimates of insurance payments are not a guarantee of payment. Any remaining balance not paid by insurance is your responsibility.

To keep our patients informed, account statements will be mailed monthly to all patients with a balance (even if insurance is still pending). Any account balance over 90 days will accrue 18% interest APR.

Appointment Agreement

We do our best to see each patient on time. Your appointment time is reserved just for you. Please understand we give our undivided attention to every patient and do not rush a procedure to meet a schedule.

In order to care for all of our patients, 48 hours notice is appreciated and expected for any change to your reserved appointment time.

A $50 cancellation fee may be applied for appointments canceled without 48 hours notice. Multiple missed appointments in a year may result in dismissal from the practice.

I understand and agree to the Financial and Appointment Agreements.

Signature_____Date_____

RAVEN Dental
Peter T. Raven, DDS LLC

Dental Self-Assessment

Your candid answers will help us better understand your concerns and expectations so that we can provide the best care possible.

1. Does dental treatment make you fearful? __No __ Slightly__ Moderately__ Extremely

2. If fearful why? __ Pain __Noises __ Environment __Past experience

(Please Explain):_____

3. On a scale of 1 to 10 (1 being poor and 10 being perfect)

   How healthy do you think your mouth is? _____

4. On a scale of 1 to 10 (1 being poor and 10 being perfect)

   How healthy would you like your mouth to be? _____

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

   If "NO", what would you like to change?

_____

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

7. Are there any additional questions about your dental health you would like to discuss?

_____

_____

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 _____

I authorize _____(spouse, friend or family member) to discuss my:

Check all that apply: Dental records____ Treatment____ Financial information____

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_____