TREELINE DENTAL

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New Patient Information

About You

First Name: _____ Middle Initial: _____ Last Name: _____
Gender: _____ Date of Birth: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Address: _____ Apt:_____ City: _____ State: _____ Postal Code: _____
Employer: _____ Occupation: _____ Work Phone: _____
Employer's Address: _____ City: _____ State: _____ Postal Code: _____

Family Information and Emergency Contact

Name: _____ Relation to Patient: _____ Phone: _____
Date of Birth: _____ **Employer:** _____ Email: _____
Address: _____ City: _____ State: _____ Postal Code: _____

Emergency Contact if Different from Above

Emergency Contact: _____ Relation to you: _____ Phone: _____
Address: _____ City: _____ State: _____ Postal Code: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____
Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____
Insurance Company Address: _____ City: _____ State: ____ Postal Code: _____
Insurance Company Phone: _____ Insurance Company Fax: _____

Secondary Insurance Company: _____ Policy Holder: _____
Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____
Insurance Company Address: _____ City: _____ State: ____ Postal Code: _____
Insurance Company Phone: _____ Insurance Company Fax: _____

Payment is Due At Time of Service

I understand that I am responsible for payment of services rendered by Treeline Dental, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the Treeline Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by Ministry of Health, CDA, ODA and PHIPA.

Dental History

What concerns you most? _____

Are you having discomfort at this time? _____ What is the discomfort? _____

How long since you have been to a dentist? _____ Did you have X-Rays? _____ What else was done? _____

Are your teeth sensitive to: heat? _____ cold? _____ sweets? _____ sour? _____ pressure? _____

Have you ever had your teeth straightened? _____ If so, when? _____ Did you have traditional braces? _____

How often do you brush your teeth? _____ How often do you use dental floss? _____

Do you have bleeding gums? _____ Have you ever had gum treatment? _____ When? _____

Do you grind or clench your teeth? _____ Do you hear popping or clicking noises when you chew? _____

Do you have any pain around either of your ears? _____ Any swelling or lumps in your mouth? _____

Do you have any fear of dental treatment? _____

How do you feel about the appearance of your teeth?_____

Medical History

Are you currently under a Physicians care? _____ Physician's Name _____

Physician's Address _____ Physician's Phone _____

Do you or have you experienced any of the following? (Select Yes/No)

Abnormal Bleeding	Select	Heart Murmur	Select	Liver Disease	Select
Alcohol Use	Select	Congenital Heart Defect	Select	Lupus	Select
Anemia	Select	Artificial Bones/Joints	Select	Hemophilia	Select
Pacemaker	Select	Radiation Treatment	Select	Emphysema	Select
Hepatitis	Select	Herpes	Select	Artificial Valves	Select
Fever Blisters	Select	Glaucoma	Select	Seizures	Select
Asthma	Select	Cancer	Select	High Blood Pressure	Select
Tobacco Use (Smoke/Chew)	Select	Tuberculosis (TB)	Select	Headaches	Select
HIV+/AIDS	Select	Kidney Problems	Select	Chemotherapy	Select
Heart Attack	Select	Colitis	Select	Diabetes	Select
Heart Surgery	Select			Venereal Disease	Select

Please list any serious medical condition(s) that you have experienced. _____

List of Medications:

_____

_____

_____

_____

Are you allergic to any of the following? (Select Yes/No)

Aspirin	Select	Erythromycin	Select	Sedatives	Select
Barbiturates	Select	Jewelry/Metals	Select	Sulfa Drugs	Select
Codeine	Select	Latex	Select	Tetracycline	Select
Dental Anesthetics	Select	Penicillin	Select	Other	Select

Please list additional drugs/materials that cause **allergic reactions**: _____

For Women: Are you taking birth control pills? _____ Are you pregnant? _____ Week #: _____ Are you nursing? _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Treeline Dental of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Signature: _____ Date: _____

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Notice of Privacy Practices Summary

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:
   a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.
   b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.
   c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
   a. To you as required by federal, state, or local law
   b. If child abuse or neglect is suspected
   c. Public Health risks for public health activities to prevent and control of disease.
   d. Lawsuits and disputes in response to a court or administrative order.
   e. Law enforcement to help law enforcement officials respond to criminal activities.
   f. Coroners, medical examiners, and funeral directors
   g. Organ or tissue donation facilities if you are an organ donor
   h. To avert a threat to individual or public health or safety

III. Disclosures where we have to give you a chance to agree or object:
   a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
   b. Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:
   1. Right to inspect your health record and to receive a copy of your health record upon request.
   2. Right to amend information in your health record you believe is inaccurate or incomplete.
   3. Right to know to whom we have disclosed your health information.
   4. Right to ask for limits on the health information data we give out about you.
   5. Right to receive communication from us about your health information in alternate ways.
   6. Right to a paper copy of the complete Notice of Privacy Practices.

I acknowledge that I have received the Notice of Privacy Practices of Treeline Dental.

Signature of Patient or Representative _____

Print Patient Name _____ Date:_____

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