FREIBERG
FAMILY DENTISTRY

Patient Information

Name:_____ Date:_____
Preferred Name:_____ Birthdate:_____ Age:____ Email:_____
Social Security #_____ Home Phone:_____ Cell Phone:_____
Address:_____ City/State:_____ Zip Code:_____
Drivers License #_____ Male____ Female____ Married____ Divorced____ Single____
Patient or Parents Employer:_____ Work Phone:_____
Spouse or Parent Name:_____ Employer:_____ Work Phone:_____
How did you hear about our office? Existing patient Mailer Internet Other:_____
Whom do we have to thank for your referral?_____
Emergency Contact:_____ Phone:_____ Email:_____
Interests or hobbies:_____

Responsible Party

Name:_____ Relationship to Patient:_____
Phone:_____ Birthdate:_____ Social Security #:_____
Employer:_____ Work Phone:_____ DL #:_____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Insured SS#:_____ Date Employed:_____
Name of Employer:_____ Employer Adress:_____
Union or Local #:_____ Employer ID #:_____ Work Phone:_____
Insurance Company:_____ Group #:_____ Policy #:_____
Insurance Company Adress:_____ City/State:_____ Zip Code:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Insured SS#:_____ Date Employed:_____
Name of Employer:_____ Employer Adress:_____
Union or Local #:_____ Employer ID #:_____ Work Phone:_____
Insurance Company:_____ Group #:_____ Policy #:_____
Insurance Company Adress:_____ City/State:_____ Zip Code:_____

Health History

Patient Name _____ Date of Birth _____ Today's Date _____

Dental History

1. **Reason for Visit/Main Concern :** ☐ Check-Up ☐ Cleaning ☐ Toothache
   Other _____
2. Are there other conditions of which we should be aware : ☐ Yes ☐ No
   If yes, please specify : _____
3. When did you last visit the dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were your last x-rays taken? _____
7. Did you have a cleaning? ☐Yes ☐No 8. Have you had gum (periodontal) treatment? ☐Yes ☐No
9. Have you ever had prolonged bleeding after an extraction? ☐ Yes ☐ No
   If yes, please specify : _____
10. Have you had any problems with past dental treatments? ☐Yes ☐No
    If yes, please specify : _____
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? ☐Yes ☐No If yes, please specify : _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction), sometimes called TMJ? ☐Yes ☐No
13. Do your gums bleed easily? ☐Yes ☐No 14. Do you feel you have bad breath? ☐Yes ☐No
15. Are your teeth sensitive to hot or cold? ☐Yes ☐No 16. Would you like your teeth whiter? ☐Yes ☐No
17. Are you happy with your smile? ☐Yes ☐No

Medical History

Please answer all questions below by checking Yes or No. All responses will be kept strictly confidential.

1. Are you in good Health? ☐ Yes ☐ No
2. Has there been any change in your general health in the past year? ☐ Yes ☐ No
3. Are you now under a physician's care for a particular problem? ☐ Yes ☐ No
4. Have you ever had any serious illnesses, operations or hospitalizations? ☐ Yes ☐ No
   If yes, describe : _____
5. **DO YOU HAVE OR HAVE YOU EVER HAD :**
   - Rheumatic Fever or Rheumatic Heart Disease? ☐ Yes ☐ No
   - Congenital Heart Disease? ☐ Yes ☐ No
   - Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ☐ Yes ☐ No
   - Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐ Yes ☐ No
   - Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ☐ Yes ☐ No
   - Liver Disease? ☐ Yes ☐ No
   - Kidney Disease? ☐ Yes ☐ No
   - Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ☐ Yes ☐ No
   - Diabetes? ☐ Yes ☐ No
   - Thyroid Disease (Goiter)? ☐ Yes ☐ No
   - Arthritis? ☐ Yes ☐ No
   - Stomach Ulcers or Colitis? ☐ Yes ☐ No
   - Glaucoma? ☐ Yes ☐ No
   - Osteoporosis? ☐ Yes ☐ No
   - Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip or Knee)? ☐ Yes ☐ No
   - Radiation (X-ray) treatment for cancer? ☐ Yes ☐ No
   - Sinus or Nasal problems? ☐ Yes ☐ No
   - Clicking or popping of jaw joint, pain near the ear, difficulty opening mouth, grind or clench teeth? ☐ Yes ☐ No
   - Any disease, drug or transplant operation that has depressed your immune system? ☐ Yes ☐ No
     If yes, describe : _____

Please turn over and fill out other side ➡

6. **ARE YOU USING ANY OF THE FOLLOWING:**

Antibiotics?	☐ Yes	☐ No
Anticoagulants (Blood Thinners)?	☐ Yes	☐ No
Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	☐ Yes	☐ No
High Blood Pressure medications?	☐ Yes	☐ No
Steroids (Cortisone, Prednisone, etc)?	☐ Yes	☐ No
Tranquilizers?	☐ Yes	☐ No
Insulin or Oral Anti-Diabetic Drugs?	☐ Yes	☐ No
Digitalis, Inderal, Nitroglycerin or other heart drugs?	☐ Yes	☐ No
Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?	☐ Yes	☐ No
Have you ever been advised NOT to take a medication?	☐ Yes	☐ No

Please list any and all medications you are taking, including prescription medications, diet drugs, herbal or holistic remedies, over-the-counter medications vitamins or minerals:

____

____

____

7. **ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD AN ADVERSE REACTION TO:**

Local Anesthesia (Novacain, etc)?	☐ Yes	☐ No
Penicillin or other antibiotics?	☐ Yes	☐ No
Sedatives, Barbiturates?	☐ Yes	☐ No
Aspirin or Ibuprofen?	☐ Yes	☐ No
Codeine or other pain killers?	☐ Yes	☐ No
Latex or Rubber products?	☐ Yes	☐ No
Metal of any kind?	☐ Yes	☐ No
Chemical or jewelry (rash or sensitivity)?	☐ Yes	☐ No
Food products?	☐ Yes	☐ No

If yes, describe: ____________________________

Other allergies or reactions? Please List. ☐ Yes ☐ No

____

____

____

8. Do you smoke or chew tobacco? ☐ Yes ☐ No
   If yes, how much per day? ________________
9. Is there any past history of alcohol or chemical dependency emotional disorder that may affect the care we provide you? ☐ Yes ☐ No
10. Have you or an immediate family member had any problem associated with intravenous anesthesia? ☐ Yes ☐ No
11. Do you have any other disease, condition or problem not listed above that you think the dentist should about? ☐ Yes ☐ No
    If yes, describe ____________________________
12. **FOR WOMEN ONLY**

Are you pregnant or **is there any chance** you might be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

If you are using ORAL CONTRACEPTIVES, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or medications is completed. Please consult your physician for further guidance.

FOR OFFICE USE ONLY:

UPDATES: ________________________

DR SIGNATURE:	DATE:

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: ____________________ Patient's Signature: ________________________

Freiberg Family Dentistry

General Consent Form

Patient Name: _____

Date of Birth: _____

Consent To Treatment

PLEASE INITIAL

_____ I do here by authorize and request the performance of dental services and the use of whatever procedures Dr. Freiberg may deem necessary for treatment. I understand that Dr. Freiberg and their staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection or ulcering. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

_____ I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office. If I do not obtain them or they are not of diagnostic quality, I permit the retaking of any necessary x-rays.

_____ I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Freiberg, or their staff will always advise me of any changes.

_____ In the event that Dr. Freiberg, or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

_____ In some case, teeth can respond negatively to even the smallest dental treatment and may require more treatment: (root canal, extraction, crowns) that is unexpected or foreseen.

_____ I understand that dental treatment is basically surgery on my tooth and may cause post operative sensitivity for a period of time. I understand that minor adjustments may be necessary after treatment for better comfort.

SIGNATURE

_____ **Patient/Guardian** **Date** _____

_____ **Printed Patient/Guardian Name**

_____ **Guardians - Relationship to Patient**

_____ **Doctor**

_____ **Witness**

You may refuse to sign this acknowledgement

Freiberg Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices dated September 23, 2013.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify: _____)