BOND
FAMILY & IMPLANT DENTISTRY

Adult New Patient Information

Welcome to our practice! Thank you so much for choosing us as your oral health care providers. Please help us gather some information about you to serve you better. **Date ___/___/_____**

Patient Name _____ Preferred Name _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Age _____

Patient's Birthdate ____/____/_____ Spouse or Parent Name _____

Home Address _____
Street City/State Zip

Emergency Contact Name and Phone _____ (_____) _____-_____

We use text messaging and email for appointment reminders.

Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____ Home (if not cell) (____) _____-_____

Email address _____

Employer Name _____Position _____ How long there? _____

Responsible Party: Social Security # _____-____-_____ Driver's License # _____

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Phone (_____) _____-_____
Street City/State Zip

Employer _____ Work Phone (_____) _____-_____

Insurance Information (please let us know if you have additional insurance coverage)

Subscriber Name _____ Birthdate ___/___/____ Relationship to Patient _____

Name of Employer _____ Work Phone (_____) _____-_____ SS# _____-_____-_____

Insurance Company _____ Plan #_____ Group # _____

Insurance Address _____ Phone (_____) _____-_____
Street City/State Zip

Referral Information

Can we thank someone for referring you?	**Or did you find us on your own?**
Family Member _____	__Looked us up on Google
Coworker _____	__Found our Website through an ad
Friend _____	__Found us through your insurance company

What is the main reason for your dental visit with us? _____

Date of last dental visit _____

Are you interested in sedation dentistry? ☐ Yes ☐ No In whitening your teeth? ☐ Yes ☐ No

Do you prefer to use Nitrous Oxide (laughing gas) during dental treatment? ☐ Yes ☐ No

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What is your main priority for your teeth? _____

Please list sensitive or painful areas in your mouth _____

Do you have any missing teeth you would like to replace? _____

Would you like to discuss cosmetic dentistry? ☐ Yes ☐ No

Do you clench or grind your teeth, or wake up with soreness in your face/jaw? ☐ Yes ☐ No

Has gum therapy or a "deep cleaning" been recommended for you in the past? ☐ Yes ☐ No

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Please indicate which of the following applies to you either currently or in the past.

Kidney Disease or Renal Dialysis	☐	Arthritis	☐
HIV Infection/AIDS	☐	Thyroid Disease	☐
Asthma	☐	Stroke	☐
Diabetes	☐	Blood Disorder, Abnormal Bleeding	☐
Liver Disease	☐	Radiation or Chemotherapy Treatment	☐
COPD or other Lung Disease	☐	Glaucoma	☐
High Blood Pressure/Hypertension	☐	Fainting, Epilepsy or Seizures	☐
Artificial Heart Valve or Heart Transplant	☐	Cancer	☐
Congenital Heart Disease, Shunts or Stents	☐	Psychiatric Therapy or Medications	☐
Rheumatic Fever, Bacterial Endocarditis	☐	Tuberculosis	☐
Heart Attack, Heart Disease, Angina	☐	Hepatitis, Any Form	☐
Pacemaker	☐	Other Conditions _____	

Please indicate if you take any of the following medications:

Pre-medication before dental treatment? Since what year? _____	No	Yes	Biaxin® (clarithromycin)	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

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Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant?	No	Yes	Due Date _____
If no, are you planning a pregnancy in the near future?	No	Yes	
Are you a nursing mother?	No	Yes	
Are you taking birth control pills?	No	Yes	

Are you allergic or have you had a reaction to:

Local anesthetics or epinephrine	No	Yes
Penicillin or other antibiotics (specify)	No	Yes
Aspirin, Ibuprofen or Tylenol®	No	Yes
Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives	No	Yes
Latex Rubber or Metals	No	Yes

Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No
Do you use any recreational or mood-altering drugs?	No

Please explain if you are currently under medical treatment _____

_____

Physician's Name _____ Phone (_____) _____-_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. You have my permission to ask my health care provider or agency to release additional information to you. I will notify the office of changes in my health and medication. I authorize the dentist to release any information including any diagnosis and records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners.

_____ _____ _____

Patient (Print Name) Patient Signature Date

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Informed Consent Form for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

There are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1.) Pain, swelling, and discomfort after treatment;
2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;
3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste;
4.) Damage to adjacent teeth, restorations or gums;
5.) An altered bite in need of adjustment;
6.) Possible deterioration of your condition which may result in tooth loss;
7.) Allergic reaction to anesthetic or medication;
8.) Infection in need of medication, follow-up procedures or other treatment;
10.) The need for replacement of restorations, implants or other appliances in the future;
11.) Need for follow-up care and treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. It is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with a general overview of potential risks and complications. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment. By signing this form, you give us consent to review and provide necessary treatment and authorize staff to perform necessary diagnostic services, including examinations, radiographs and teeth cleaning (scaling).

_____ _____

Signature of Patient, Parent or Legal Guardian (if a Minor) Date

_____

Witness Signature