Matthew E. Walker DDS & John P. Walker DDS

Downtown Family Dentistry

PATIENT INFORMATION

First Name: _____MI: ____Last: _____ Nick Name:_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

DOB: _____ □ Male □ Female SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer_____

State ID/Driver's License #: _____E-mail Address: _____

RESPONSIBLE PARTY: □ same as above

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____

City: _____State: _____ Zip: _____

Home Phone:_____ Work phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance Name: _____ Secondary Insurance Name:_____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____

Relationship:_____ Phone:_____

How did you hear about our office? _____

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PATIENT HEALTH HISTORY

Do YOU have a history of:

AIDS/HIV Positive	☐	Glaucoma	☐	Malignancies	☐
Alcoholism	☐	Hay Fever	☐	Mental Health Disorders	☐
Allergies	☐	Head Injuries	☐	Mitral Valve Prolapse	☐
Anemia	☐	Hearing Impaired	☐	Neck & Back Problems	☐
Arthritis	☐	Heart Disease	☐	Nervous Problems/Disorders	☐
Asthma	☐	Heart Valve, Murmur, Stents	☐	Pacemaker	☐
Auto Immune Disorder	☐	Hepatitis/Liver Disease	☐	Prosthetic Joints	☐
Type(s)_____		Type(s)_____		Radiation Treatment	☐
Blood Disease	☐	Hepatitis Carrier	☐	Respiratory Problem/Disorder	☐
Bone Disorder	☐	High Blood Pressure	☐	Rheumatic Fever	☐
Cancer	☐	Hip or Joint replacement	☐	Scarlet Fever	☐
Chemical Dependency	☐	HPV	☐	Seizures/Fainting Spells	☐
Chest Pain	☐	Jaundice	☐	Sinus Problems	☐
Circulatory Problems	☐	Kidney Disease	☐	Stroke	☐
Convolsions/Seizures	☐	Kidney Dialysis	☐	Thyroid Disease	☐
Diabetes	☐	Latex Sensitivity	☐	Tuberculosis	☐
Excessive Bleeding	☐	Lupus	☐	Tumors or growth	☐
Epilepsy	☐	Low Blood Pressure	☐	Ulcers	☐

MEDICAL QUESTIONS

List any medications you are taking (including nonprescription drugs)

_____

_____

_____

Do you have any disease/problem you think we should know about? ☐ YES ☐ No If yes, please explain below:

_____

_____

_____

Are you allergic to any medications? ☐YES ☐No
If yes, please list below:

_____

_____

_____

Are you in good health? ☐YES ☐No

Date of Last Medical Exam:_____

Please list any hospitalizations and/or surgeries below:

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ☐YES ☐No

Have you had an allergic reaction to any food? ☐YES ☐No

Do you smoke or chew tobacco? ☐YES ☐No

Have you had Heart Surgery? ☐YES ☐No

Are you now under the care of an MD? ☐YES ☐No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc.) ☐YES ☐No

FOR WOMEN ONLY:

Are you taking birth control pills? ☐YES ☐No

Are you pregnant? ☐YES ☐No Expected due date:_____

Are you nursing/breastfeeding? ☐YES ☐No

Is there a possibility of pregnancy? ☐YES ☐No

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DENTAL HISTORY INFORMATION

Date of last dental visit?_____ Name of your previous dentist_____ Reason for today's visit?_____	Do you snore? □YES □No Do you have problems with bad breath? □YES □No Have you ever had an allergic reaction to a crown, metal filling, or dental appliance? □YES □No
Have you ever had an oral cancer screening? □YES □No	Have you ever used an electric toothbrush? □YES □No Are your teeth sensitive to hot, cold, or pressure? □YES □No
How often do you floss your teeth?_____ Do your gums bleed when you brush? □YES □No Have you ever had complications from an extraction? □YES □No	On a scale from 1 to 10, with 10 being the ***highest***, how important is your dental health to you? 1 2 3 4 5 6 7 8 9 10
Have you ever had a popping or clicking near your ear when you chew? □YES □No	If you could change something about your smile what would it be:
Are you prone to frequent headaches? □YES □No Do you clench or grind your teeth? □YES □No	□Whiter □Straighter □Close space □Replace unsightly fillings
Do you have sores, blisters or swelling on your gums lips or cheeks? □YES □No	□Repair chipped teeth □Replace missing teeth
Have you ever had orthodontic treatment? □YES □No	□Less gums showing □Replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient
Signature: _____ Date: _____

Parent/Guardian (if patient is a minor):
Signature: _____ Date: _____

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering professional services by any member of Downtown Family Dentistry, dba Matthew E. Walker, John P. Walker and or any staff member of Downtown Family Dentistry, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other arising out of this agreement, all disputes shall be resolved through arbitration.

Signature:_____ **Date**:_____

*I have read the above conditions of treatment and payment and agree to their content.

Below are the most common complications with dental procedures. Please read these and ask the dentist any questions you may have regarding your treatment. Understanding that because of the nature of dental problems and treatment, there are no guarantees as to success or failure.

Injections – swelling, bruising, soreness, and on rare occasions long-term or permanent numbness. TM Joint dysfunction has been noted in select cases.

Fillings – recurrent decay, breakage, tooth sensitivity, may require root canal treatment, crown, or extraction. TM Joint dysfunction has been noted in select cases.

Crowns – recurrent decay, crown coming loose, tooth sensitivity, may require replacement, re-cementation, root canal treatment, or extraction. TM Joint dysfunction has been noted in select cases.

Bridges – the same as a crown. Also, a bridge can break requiring replacement. TM Joint dysfunction has been noted in select cases.

Root Canals – persistent pain, infection, swelling, instrument separation which may require further treatment by a specialist or an extraction. TM Joint dysfunction has been noted in select cases.

Extractions – persistent bleeding, pain, infection, swelling, oral-sinus communication, root tip breakage, permanent numbness in general area of extraction, requiring further treatment by a specialist. TM Joint dysfunction has been noted in select cases.

Partials – soreness from new partial requiring adjustment, difficulty with speech and eating, metal allergies. TM Joint dysfunction has been noted in select cases.

Dentures – the same as Partials. TM Joint dysfunction has been noted in select cases.

Periodontal Treatment – persistent bleeding, infection, pain, swelling, tooth loss. Possible need for re-treatment or further treatment by a periodontal specialist. TM Joint dysfunction has been noted in select cases.

Implants – implant fails (in some cases soon after placement), infection, long-term or permanent numbness, loss of bone around implant due to gum disease. TM Joint dysfunction has been noted in select cases.

I have read the above information about the possible complications of dental treatment and have had the opportunity to ask any questions I have involving my treatment.

Signature:_____ **Date**:_____

OUR INSURANCE POLICY

As a courtesy to our patients we will be glad to file your dental insurance for you; however your insurance is a contract between you and the insurance company. Because there are several insurance plans and policies, it is impossible for us to know everyone's dental coverage. We cannot be responsible for what the insurance companies do not pay. We do our very best to give you the most accurate estimate according to our experience but it is your responsibility to know your own insurance coverage. Your estimated co-pay is due at the time of service unless prior financial arrangements have been made with the Office Manager.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

I have received a copy of the Notice of Privacy Practices

By signing I understand and accept the above policies

Signature:_____**Date**:_____