Dr. Dollins

Patient Information (confidential)

Date:_____

Name:_____ Birthdate_____Referred by:_____

Address_____City_____State_____Zip_____

HomePhone_____CellPhone_____Email_____

Occupation_____Employer_____Work Phone_____

Check Appropriate Boxes:☐Male☐Female☐Minor☐ Single☐Married☐Divorced☐Widowed☐Separated

Physician_____Phone_____Date of Last Exam_____

Person to contact in case of emergency_____Phone_____Relationship_____

Health Information :

Have you ever had any of the following? Please check those apply:

Y/N

☐☐AIDS/HIV
☐☐Anemia
☐☐Anxiety or excessive stress
☐☐Allergies_____
☐☐Arthritis
☐☐Artificial Joints/ Implants
☐☐Asthma
☐☐Back Pain or Sciatica
☐☐Bell's Palsy
☐☐Biphosphonates for Bone Loss
☐☐Birth Control Pills
☐☐Blood Disease
☐☐Cancer_____
☐☐Chemical Sensitivity
☐☐Chemotherapy
☐☐Chronic Bronchitis
☐☐Chronic Fatigue
☐☐Chronic Headaches
☐☐Chronic Muscle/Joint Pain
☐☐Circulatory Problems
☐☐Cough,persistent or bloody
☐☐Covid 19
☐☐Depression
☐☐Diabetes
☐☐Difficulty Sleeping
☐☐Drug Addiction
☐☐Eye Conditions
☐☐Emphysema
☐☐Endocarditis
☐☐Epilepsy
☐☐Excessive Bleeding
☐☐Fainting or dizziness
☐☐Frequent Sore throats
☐☐Frequent Urination
☐☐Glaucoma

Y/N

☐☐GI Disorders
☐☐Hay Fever
☐☐Headaches
☐☐Head Injuries
☐☐Heavy Metal Toxicity
☐☐Heart Attack
☐☐Heart Disease
☐☐Heart Murmur
☐☐Hepatitis Type_____
☐☐Herniated Disk
☐☐Herpes
☐☐High/Low Blood
☐☐High/Low Thyroid Hypoglycemia
☐☐Insomnia
☐☐Jaundice
☐☐Jaw Pain
☐☐Kidney Disorders
☐☐Low body temperature
☐☐Lymph Glands swell frequently
☐☐Palpitations
☐☐Premedicate
☐☐Pressure
☐☐Kidney Disease
☐☐Liver Disease
☐☐Lupus
☐☐Lyme's Disease
☐☐Mental Disorders
☐☐Mitral Valve Relapse
☐☐Multiple Sclerosis
☐☐Neck Pain
☐☐Nervous Disorders
☐☐Numbess fingers and toes
☐☐Osteoporosis/Osteopenia
☐☐Pacemaker

Y/N

☐☐Pregnancy
Due date:_____
☐☐Psychiatric/Emotional care
☐☐Rapid fatigue
☐☐Radiation Treatment
☐☐Rheumatic Fever
☐☐Rheumatism
☐☐Shaky Hands/Feet
☐☐Shortness of Breath
☐☐Short term memory loss
☐☐Skin Problems
☐☐Sinus Problems
☐☐Sleep Apnea
☐☐Special Diet _____
☐☐Snoring
☐☐Stroke
☐☐Swollen feet or Ankles
☐☐Swollen Neck Glands
☐☐Tingling in my body
☐☐Trouble making decisions
☐☐Tuberculosis
☐☐Twitching of Muscles
☐☐Tumors or
growth on head or neck
☐☐Ulcers
☐☐Urinary Troubles
☐☐Venereal Disease (STD)
☐☐Use Sugar Substitutes
☐☐Use Tobacco, pipe or cigar smoking
☐☐Use Recreational Drugs
☐☐Use Fen Phen
☐☐Use Hormones
☐☐Weight Loss,unexplained
☐☐Work around mercury

Allergies(Please list the response next to each allergy- i.e. rash, hives, anaphylaxis)

☐Acrylic ☐Latex ☐Sleeping Pills
☐Aspirin ☐Local Anesthetic ☐Sulfa Drugs
☐Codeine ☐Metal ☐Others_____
☐Iodine ☐Penicillin

List any medications you are currently taking and the correlating diagnosis:

Medication Name	Dosage	Diagnosis

(if any additional medications please attached a separate page)

Nutritional Supplements:☐None ☐Multivitamins ☐Trace Minerals ☐ EPA-DHA(Omega 3's)
☐Macro-Minerals(Zinc,Magnesium)☐Probiotics ☐Digestive Enzymes ☐AminoAcids ☐Antioxidants
☐Superfoods ☐Others_____

Are you under medical treatment right now?☐Yes ☐No
Have you ever been hospitalized for any surgical operation/serious illness within the last 5 yrs?_____
If yes, please explain _____
Are you wearing contact lenses? ☐Yes ☐No
Women only: a) are you pregnant or think you may be pregnant ☐Yes ☐No
b) Are you nursing? ☐Yes ☐No
c)Are you taking any contraceptives Yes ☐ No☐

Dental Information:

Reason for today's visit_____
Date of last dental visit:_____Date of last X-rays_____Date of Last Hygiene_____
Previous Dentist:_____City/State_____Reason for leaving:_____
Have you ever taken an antibiotic prior to dental treatment? ☐Yes ☐ No
Have you ever had any problem associated with dental anesthetic? ☐Yes ☐No

Y / N	Y / N	Y / N
☐☐Bad Breath	☐☐ Food collection between teeth	☐☐Pain around the ear
☐☐Bleeding Gums	☐☐Grinding Teeth	☐☐Periodontal treatment
☐☐Blisters on lips or mouth	☐☐Jaw pain or tiredness	☐☐Sensitivity to cold
☐☐Burning sensation on tongue	☐☐Lip or cheek biting	☐☐Sensitivity to heat
☐☐Chew on one side of mouth	☐☐Loose teeth or broken fillings	☐☐Sensitivity sweets
☐☐Clicking or popping jaw	☐☐Metallic taste	☐☐Sensitivity when biting
☐☐Dentures or partial	☐☐Mouth breathing	☐☐Sores or growths in your mouth
☐☐Dry mouth	☐☐Mouth pain, brushing	How often do you floss_____
☐☐Fingernail biting	☐☐Nightguard	How often do you brush?_____
☐☐Gum Swollen or tender	☐☐Orthodontic treatment	

Is having silver mercury fillings a concern for you? ☐Yes ☐No
Are you accustomed to seeing a dentist on a regular basis ? ☐Yes ☐No
Please rate your comfort level with receiving dental treatment: ☐No problem☐ Slight ☐Moderate
Please describe any problems you have had with past dental experiences _____

Is Biologic Dentistry (using materials that are compatible with your body)an interest to you? ☐Yes ☐ No
Do you believe that the health of the mouth can affect the health of the whole body? ☐Yes ☐ No

Patient Agreement to Office Policies

Dr Dollins appreciates your trust and interest in scheduling a new patient exam. We take pleasure in reserving a special amount of time to listen to your specific needs knowing you are wanting the highest quality of care and time to discuss your unique situation.

Financial Agreement

As a condition of your treatment by this office, financial agreements must be made in advance. I understand that all responsibility of payment for the dental work provided in the office for my dependents or myself is mine, due and payable at times services are rendered unless other arrangements have been made. I understand that the fee estimate listed for this dental care can be extended for a period of 6 months from the date of the patient examination. _____I

Insurance Filing

Patients who carry dental insurance understand that all dental service furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help patients by providing treatment information for their insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand this facility is not a participating provider of my insurance network and that I will be financially responsible for any additional out-of-pocket costs that may result. I further acknowledge that it is my responsibility to verify my out-of-network benefits with my insurance company and I will not hold Dr Dollins DDS liable for any obscure or omitted contractual language in my insurance contract. _____I.

Returned Checks

I understand that there will be a $35 insufficient funds fee added to my account in the event of a returned check.

Collection Proceedings

In the event my account is turned over to a collection agency for non-payment or other delinquency, I will be responsible for a payment of any collection cost (30%) and /or attorney fees. In addition to the balance owed. Any account turned over to a collection agency forfeits any past special fee and/or discount. Such special fees and /or discounts will be reserved and I will be responsible for payments of regular fee for procedure at the time of service.

Failed Appointments

If I arrive more than **15 minutes late** for my appointment, I may ask to reschedule. Any appointments that are not confirmed in **24 hours** will be removed from our schedule. I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a **72-business hour notice**. Failure to do so will result in cancellation fee of $75/hr. If I am considered a no show for three missed appointments or have excessive cancellations, Dr Dollins' retains the right to dismiss me from the practice. _____I.

Change of Information

I understand that it is my responsibility to advise this office of any change in the information I provide regarding my patient information and health form. _____I.

Acknowledgment of Receipt of Notice of Privacy Practice

I have received a copy of this office's Notice of Privacy Practice. I understand that I have the right to refuse to sign this acknowledgment. _____I.

Patient Dismissal

I understand that there are grounds for immediate dismissal as a patient from Dr Dollins DDS if any offenses are committed; the offenses include, but are not limited to: rude or abusive behavior toward any staff member, non-compliance with treatment plans, medication misuse, multiple missed office visits, failure to pay on the account. _____I.

Email and/or Text Message for Appointment Reminders and Other Healthcare Communications

Patients in this practice may be contacted via email and/or text messaging to remind them of an appointment, to obtain feedback on their experience with the healthcare team, and to provide general health reminders/information. I consent to receiving appointment reminders and other healthcare communications/information through email and/or text _____ I.

Pediatric Patients Only

In order for the staff to develop a patient/doctor relationship with your, we ask that you stay in the waiting room during your child's treatment. Children act differently without the parents around and in this way, we can get to know your child better. Don't worry, we will never do a procedure without your consent. WE take a great amount of time explaining everything we do to the child and to you. If you have any questions, don't hesitate to ask, and encourage your child to ask as well. We also take time to work through any fears the child may have of the dentist and our surroundings. That is why we allot as much time as any adult being treated. During the first visit, we talk to the child, answer questions, do a cleaning, take X-Rays (after age 6), and give a complete head, neck, and oral exam. For younger children, we will complete as much as the child will allow us. Afterward, we will bring the parent(s) into the exam room, discuss our findings, treatment plan, and costs, and answer questions. WE will not force your child to do anything against their will. This only encourages fear and dislike of dentists as well as other doctors. Please do not threaten or use "scare tactics" to get your child to cooperate with us. If we absolutely cannot get your child to coorperate, we may refer her/him to a pediatric dentist (a dentist who specializes in child dentistry)._____I.

EXAM VIA TELEDENTISTRY CONSENT FORM

Advanced Dental Centers will be using TeleDent's remote communication technology to conduct problem-focused evaluations/re-evaluations virtually, to help manage your oral health problem and to determine whether you have a condition that requires immediate in-office treatment.

During the current pandemic the federal government announced that it will not enforce HIPAA regulations (privacy for health records) in connection with medical and dental offices' good faith provision of medical or dental services using non-public facing audio or video remote communications services. Remote patient consultations may take place over applications that allow video chats such as Apple Face Time, Facebook Messenger video chat, Google Hangouts, Skype, or Zoom and may involve or be based on photos or videos taken with smart phones by the patient and transmitted to the dental office. Please do not contact us using public-facing services such as Facebook Live, Twitch, or TikTok, which are not permitted by the federal government for this purpose.

As always, our office will take dental record confidentiality very seriously, and will do what we can under the circumstances to protect the information you send us. While we believe the risk to such confidentiality is not high, it may be greater than it would be if these remote electronic communications were encrypted, which is one of the main HIPAA requirement's that is being relaxed during the nationwide COVID-19 public health emergency.

Certain major dental plans have announced that they will reimburse dental offices for conducting such remote evaluations, and we will submit claims in connection with them.

Our dental office is using one or more of the permitted modalities listed above for remote transmission of information to conduct limited problem focused evaluations. While entirely adequate in the vast majority of cases for such limited purposes, these evaluations may not reveal conditions that would be discovered during an office visit or through the use of specialized teledentistry technology.

Please indicate your understanding of and informed consent to these terms, which will be in effect until the government rescinds its suspension of these HIPAA requirements, by sign your name in the space provided and return via email to this office.

_____

Patient Signature

_____

Date