Zimmerman Family Dentistry

Upon arrival, please confirm your address, phone number, and insurance status with a team member. You will be asked to provide a photo ID.

Patient Name: _____ Preferred Name: _____ DOB: _____

Parent/Guardian Name if patient is considered a minor (*under 18 years old*): _____

Cell #: _____ Home #: _____ Do you allow detailed messages to be left on these numbers? ☐ YES ☐ NO

All appointments *must be confirmed* for reserved time on our schedule. Appointment times will be confirmed *via text*. If an appointment is not confirmed, the office will contact you by phone. It is the patient's responsibility to ensure the correct contact information is on file.

Please read and ✓ the box to acknowledge your understanding of the following:

☐ ***I understand it is my responsibility to inform Zimmerman Family Dentistry (ZFD) of any changes or updates to my contact information AND my insurance information.***

☐ ***I understand minors (under age 18) MUST bring a signed consent to treat to ALL visits if the parent/legal guardian is not present. If the guardian is not present and the form is not completed, dental providers are not legally permitted to treat the minor.***

☐ ***I understand a 24-hours' notice is required for all appointment changes. Failure to show for an appointment or give less than a 24-hours' notice may result in a $50 fee for each appointment.***

INFORMATION RELEASE (***Required*** *by HIPPA*)

Emergency Contact Name: _____ Relation: _____ Phone number: _____

Do you give ZFD consent to release your patient health information (PHI) to your emergency contact listed above? ☐ YES ☐ NO

List any other individuals to whom you give ZFD consent to release your PHI (*Information will **ONLY** be provided to individuals listed*):

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

I acknowledge that I have read and understand the Privacy Policy Notice (HIPPA) and Office Policies and Procedures. ZFD will only use your Patient Health Information (PHI) for the purpose of treatments, payments, healthcare operations, and coordination of care. I further understand that if I fail to show for an appointment or give less than 24-hours' notice, ***I may incur a $50 fee for each appointment***. Billing fees may be applied to any balances past 60 days. I authorize the transfer of radiographs and dental records for referred treatment and in the event of transfer to another general dentist or dental specialist.

Photographs, x-rays, and digital images may be used for diagnosis, documentation, reference, teaching, social media and research publication. Although your full face will not be shown without your consent, in some instances, you may be recognizable. Please initial the following:

_____ I authorize the use of images and radiographs for the patient listed above.
_____ I DO NOT authorize the use of images and radiographs for the patient listed above.

I understand that I have the right to revoke this authorization, in writing, at anytime by notifying the office.

INFORMED CONSENT AGREEMENT

I give consent to receive dental treatment deemed necessary by the providers at Zimmerman Family Dentistry. These procedures include, but are not limited to, examinations, oral prophylaxes, fluoride treatments, sealants, fillings, crowns, bridges, implants, dentures, partials, periodontal treatment, endodontic treatment, extractions and the use of local anesthetic and nitrous oxide. I understand that the use of local anesthetics caries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or in rare cases prolonged or permanent nerve damage. This consent shall be considered in effect until rescinded or revoked in writing.

_____

Patient Signature (or Legal Parent/Guardian) **Date**

TURN TO BACK ⇨

DENTAL HEALTH HISTORY

Last dental visit? ☐ within 12 months ☐ more than 1 year ☐ more than 5 years
Are you happy with your smile? ☐ Yes ☐ No
Are you interested in nitrous oxide "laughing gas" to help you relax during dental procedures? ☐ Yes ☐ No

Please review the following dental concerns and ✓ all that apply:

Loose teeth or lost fillings? ☐ Yes
Missing teeth/spaces? ☐ Yes
Wear dentures or partials? ☐ Yes
Discomfort when chewing? ☐ Yes
Swollen, tender or bleeding gums? ☐ Yes
Bad breath? ☐ Yes

Food collection between teeth? ☐ Yes
Braces currently or in past? ☐ Yes
Dry mouth? ☐ Yes
Clenching/grinding teeth? ☐ Yes
Jaw pain? ☐ Yes
Clicking or popping jaw? ☐ Yes

Sensitivity to cold or hot? ☐ Yes
Sensitivity when biting? ☐ Yes
Trauma to face and/or jaw? ☐ Yes
Sores or growths in mouth? ☐ Yes
Blisters on lips or mouth? ☐ Yes
Burning sensation on tongue? ☐ Yes

MEDICAL HEALTH HISTORY

My preferred pharmacy is: _____

I take blood thinners (anticoagulants and/or antiplatelets). ☐ Yes ☐ No
Name(s) of blood thinners: _____

I take or have taken medications for osteoporosis (bisphosphonates). ☐ Yes ☐ No
Name(s) of medication(s) for osteoporosis: _____

Patients taking medications for blood thinners or osteoporosis may require a medical clearance from the prescribing medical doctor for certain dental procedures, like extractions. The clearances should include instructions on whether any medication must be stopped for a period of time prior to the dental procedure.

I require a premedication antibiotic for dental appointments. ☐ Yes, please specify name: _____

I have an artificial joint(s). ☐ Yes, please specify joint(s) & date(s): _____
Refills for premedication antibiotics should be requested from the prescribing doctor; providers at ZFD cannot refill the antibiotic.

I have a pacemaker. ☐ Yes, date of placement: _____

I received an organ transplant. ☐ Yes, please specify organ & date: _____

I have a history of radiation treatment on my head and/or neck. ☐ Yes, please specify location & date: _____

I am pregnant. ☐ Yes, due date: _____ **I am nursing.** ☐ Yes

I have allergies. ☐ Yes, please specify: _____

A list of all other medications ***must*** be provided to the office, or they may be listed here: _____
_____

Please review the following medical concerns and ✓ all that apply:

High blood pressure? ☐ Yes
Low blood pressure? ☐ Yes
High cholesterol? ☐ Yes
Arthritis? ☐ Yes
Asthma? ☐ Yes
Artificial heart valve? ☐ Yes
Stent placed? ☐ Yes
History of stroke? ☐ Yes
History of heart attack? ☐ Yes
Autoimmune disease? ☐ Yes
Which autoimmune disease? _____

Frequent headaches? ☐ Yes
Neck/back pain? ☐ Yes
Bleeding disorder? ☐ Yes
Blood disease? ☐ Yes
Ulcer/GERD? ☐ Yes
Diabetes? ☐ Yes
Sleep apnea? ☐ Yes
Dementia/Alzheimer's? ☐ Yes
Aids/HIV? ☐ Yes
Epilepsy or seizures? ☐ Yes

Leukemia? ☐ Yes
Cancer? ☐ Yes
Chemotherapy/radiation? ☐ Yes
Kidney disease? ☐ Yes
Liver disease? ☐ Yes
Respiratory disease? ☐ Yes
Circulatory abnormalities? ☐ Yes
Treated for anxiety or depression? ☐ Yes
Chemical dependency? ☐ Yes
Tobacco Use? ☐ Yes

_____

Patient Signature (or Legal Parent/Guardian) **Date**