32 U™ FAMILY DENTAL & ORTHODONTIC ARTS

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev.
Preferred Name _____
Address _____ City, State, Zip _____
[ ] Male [ ] Female Date of Birth ___/___/_____ Social Security number_____-_____-_____

Best number for contact:
[ ] Cell Phone _____ [ ] Home Phone _____
[ ] Work Phone _____ [ ] Other _____
Email address _____
Preferred method for appointment reminders [ ] Text [ ] Email [ ] Phone
Employer _____Occupation _____

Which best describes you: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Minor
Spouse's Name _____

Responsible Party (if different than patient)
Name _____ Relationship to patient _____
Date of birth ___/___/_____ Social Security Number _____-_____-_____
Address _____ City, State, Zip _____
Cell #(___)_____ Home # (___)_____ Work #(___)_____

Insurance Information
Medical Insurance
Subscriber's name _____ Relationship to patient_____
Address _____ City, State, Zip _____
DOB ___/___/_____ Subscriber's SSN _____-_____-_____
Insurance Company _____ Policy # _____Group # _____

Dental Information
Subscriber's name _____ Relationship to patient_____
Address _____ City, State, Zip _____
DOB ___/___/_____ Subscriber's SSN _____-_____-_____
Insurance Company _____ Policy # _____Group # _____

Do you have additional Dental insurance? [ ] Yes [ ] No
Subscriber's name _____ Relationship to patient_____
Address _____ City, State, Zip _____
DOB ___/___/_____ Subscriber's SSN _____-_____-_____
Insurance Company _____ Policy # _____Group # _____

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Medical History

Please provide information of the following or any other medical problems you have encountered or medicines that you are currently taking as these could have the potential to have an impact on your dental needs and the dentistry that we may need to provide. Please indicate if you have any of the following:

Allergies

- Acrylics ☐
- Latex ☐
- Local Anesthetics ☐
- Penicillin ☐
- Metal ☐
- Sulpha ☐
- Other ☐

List known allergies:

_____

_____

_____

Endocrine

- Diabetes ☐
- Gout ☐
- Hormonal Change ☐
- Thyroid problems ☐

Respiratory

- Asthma ☐
- Bronchitis ☐
- Breathing Trouble ☐
- Chest Pain ☐
- Emphysema ☐
- Pneumonia ☐
- Pulmonary Embolism ☐
- Tuberculosis ☐

Oral

- Bleeding gums ☐
- Dry Mouth ☐
- Jaw Problems (TMJ) ☐
  - Clicking ☐
  - Pain ☐
- Previous Orthodontics ☐
- Tooth Pain ☐
- Troubles with extraction ☐
- Do you need premed ☐

Heart and Related

- Artificial Heart Valve ☐
- Chest Pain (Angina) ☐
- Congestive Heart Failure ☐
- Coronary Artery Disease ☐
- Heart Attack ☐
- Heart Murmur ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Pacemaker ☐
- Tachycardia ☐

Hematological

- Bleeding problems ☐
- Hepatitis ☐

Eyes, Ears, Nose & Throat

- Change in Hearing ☐
- Change in Vision ☐
- Glaucoma ☐
- Sinus Problems ☐
- Tonsillectomy ☐
- Trouble swallowing ☐
- Tinnitus (ringing in ears) ☐

Musculoskeletal

- Back Pain ☐
- Fibromyalgia ☐
- Joint Pain ☐

Gastrointestinal & Urinary

- Acid Reflux ☐
- GERD ☐
- Soft or Special Diet ☐
- Ulcers ☐
- Frequent Urination ☐
- Kidney Disease ☐
- Liver Disease ☐

Nervous System

- Alzheimer's Disease ☐
- Dizziness ☐
- Fainting ☐
- Memory Loss ☐
- Multiple Sclerosis(MS) ☐
- Seizures ☐
- Stroke ☐
- Tingling/Numbness ☐
- Trigeminal Neuralgia ☐
- Tremors ☐
- Muscle Weakness ☐

Psychiatric

- ADD/ADHD ☐
- Anxiety ☐
- Chemical Dependency ☐
- Depression ☐
- Eating Disorder ☐
- Excessive Stress ☐
- Memory Trouble ☐

Sleep

- Sleep Apnea ☐
- CPAP machine? ☐
- Snoring? ☐

Lifestyle

- Do you smoke? ☐
- #_____ packs per day
- Smokeless or chewing tobacco? ☐
- Do you consume alcoholic beverages? ☐
- #_____Drinks per D/Wk/Mo
- Recreational drug use? ☐
- HIV/AIDS ☐
- Unexplained weight loss ☐

General Health

Current Weight _____ lbs

Current Height ____ ft _____ in

- Cancer ☐
  - Radiation tx ☐
  - Chemotherapy ☐
  - Remission ☐
- Artificial Joints ☐
- Recent trauma or injury ☐
- Rheumatic Fever ☐

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Medical History and Consent to Treat

List all medications currently taking
Include the name of Med/Dosage/Reason

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

List any surgeries you have had
Include Date of surgery/Surgeon/Reason

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

Please inform us of any medical condition or history that is not listed above:

_____
_____
_____

Primary Physician _____ Physician's Phone # (___)_____

Are you currently under the care of a physician? If so, please list:

Physician Phone # Reason for care

_____
_____
_____

General consent to diagnose and treat: The undersigned hereby authorizes 32 & You, P.C. to take radiographs, photographs, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize 32 & You, P.C. to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that 32 & You, P.C. choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embody certain risk and consent to their use as deemed appropriate by 32 & You, P.C. The answers given are accurate to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform 32 & You, P.C. of any changes in medical health or status.

Financial Consent: I understand that responsibility for payment of services provided in this office for myself and/or my dependent(s) is mine, due and payable at the time of services are rendered. I understand that any dental insurance I may have, is a financial assistance and that I am responsible for any portion of fees rendered that are not covered by my medical or dental insurance (if any). I further consent to and agree to pay a 1.5% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize 32 & You, P.C. and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Please indicate which payment method you prefer:

Cash or check ☐ Visa/Mastercard ☐ Care Credit ☐

Consult

Name of patient: _____ Date:_____/_____/_____

Adult patient/ parent or guardian signature _____

Notice of Privacy Practices: Patient privacy is important to 32 & You, P.C. We are required by law to maintain the privacy of protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if any) and my medical providers.

Signature of Patient or Parent/Legal Guardian:_____ Date: ____/_____/_____