Pure Dental

Today's Date: _____

Patient Information

Name:_____ **Date of Birth**:_____ **Age**:_____
Last First MI

Preferred Name: _____ **Gender**: _____ **Marital Status**:_____ **Social Security**: _____

Address:_____
Street City State Zip Code

Home Phone: (_____)_____ **Cell**: (_____)_____ **E-mail**: _____
☐ Check Box to Opt-out of texting from Pure Dental

Occupation: _____**Employer Name**:_____ **Phone**:_____

***How did you hear about us?** ☐ Website: _____ ☐ Natural Awakenings
(check all that apply)
☐ Doctor: _____ ☐ Friend Name: _____ ☐ IAOMT

☐ Other:_____ ☐ Holistic/Natural Dentistry ☐ Holistic Dental Association (HDA)

Emergency Contact

Name:_____ **Relationship**: _____ **Best Phone**: (_____)_____

Insurance Information

I have dental insurance: Yes ☐ No ☐ If yes, please give a copy of your insurance card to the front desk.

Medications

☐ no medications

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

Pharmacy:_____ **City:**_____

Medication:_____ Diagnosis:_____
Medication:_____ Diagnosis:_____
Medication:_____ Diagnosis:_____
Medication:_____ Diagnosis:_____
Medication:_____ Diagnosis:_____

Allergies

No Known Allergies... ☐

Aspirin..... ☐ Latex..... ☐
Barbiturates (sleeping pills). ☐ Local Anesthetic.. ☐
Codeine..... ☐ Penicillin..... ☐
Iodine..... ☐ Sulfa..... ☐
Other: _____

- Flip Over -

Dental Information

For the following questions, please mark (X) on your responses to the following questions.

DK = Don't know

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Do you have mouth pain during or after brushing?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) disease?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Do you use a cigarette, pipe, or cigar smoking?	☐	☐	☐
Do you grind your teeth?	☐	☐	☐
Do you experience jaw pain or tiredness?	☐	☐	☐
Have you had or currently have sore or growths in your mouth?	☐	☐	☐
Do you have pain around your ear?	☐	☐	☐
Are you currently experiencing any dental pain or discomfort?	☐	☐	☐

How often do you floss?

_____

How often do you brush?

_____

Date of your last dental visit?

_____

Name of former Dentist/Office?

_____

Date of last dental x-rays?

_____

Reason for today's visit?

_____

_____

Medical Information

For the following, please mark (X) on your response to indicate if you have or have not had any of the following diseases or problems.

Physician's Name:_____ **Phone Number:**_____

DK = Don't know

	Yes	No	DK
AIDS/HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis, Rheumatism	☐	☐	☐
Artificial Heart Valves / Joint	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Autoimmune Disorder	☐	☐	☐
Bleeding abnormally w/ extractions or surgery	☐	☐	☐
Blood Pressure (High/Low)	☐	☐	☐
Cancer	☐	☐	☐
Chemotherapy	☐	☐	☐
Cholesterol (High)	☐	☐	☐
Congenital Heart Lesions	☐	☐	☐
Developmental Disability	☐	☐	☐
Diabetes	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting or Dizziness	☐	☐	☐
Glaucoma	☐	☐	☐
Headaches	☐	☐	☐
Heart Murmur	☐	☐	☐
Hepatitis Type ____	☐	☐	☐
Jaundice	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Lung Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Neurological Disorder	☐	☐	☐
Osteoporosis	☐	☐	☐
Pacemaker	☐	☐	☐
Pregnant / Nursing	☐	☐	☐
Estimated Due Date: _____			
Radiation Treatment	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Sensory Sensitivity	☐	☐	☐
Sinus Trouble	☐	☐	☐
STD	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Problems	☐	☐	☐
Tuberculosis	☐	☐	☐
Ulcer	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐

Do you have any disease, condition, or problem not listed above that you think that we should know about? Yes ☐ No ☐

If yes to last question, please explain:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Private Practice: You have the right to read our Notice of Private Practices before you decide whether to sign the consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our private practices as described in our Notice of Privacy Practices. If we change our private practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Amy Truong
Telephone: (651) 731-3064 **Fax: (651) 731-9340**
E-mail: PureDentalMN@gmail.com
Address: 6230 10th St. N. Suite 520, Oakdale, MN 55128

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person handed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you receive this consent.

I have had full opportunity to read and consider the contents of this Consent form of your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____**Date**:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

- Flip Over -

*marked stars are required to be reviewed and signed

*Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Truong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions whether manual or electronic.

The above-named dentist may use my health care information and may disclose such information to Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature:_____**Date**:_____

*Financial and Cancellation/Rescheduling

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. Patients with dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, or credit card.

I acknowledge that Pure Dental requests at least 48 hour notice for CANCELLATION OR RESCHEDULING. If there are any cancellations or rescheduling within 48 hours, Pure Dental reserves the right to charge a **$50.00** cancellation/reschedule fee automatically after two consecutive broken appointments. To avoid missed appointment charges we request that canceling/rescheduling is made at least 48 hours prior to scheduled appointment.

Signature:_____**Date**:_____

Minor/Child Consent Under 18 Years Old

I, being the legal parent or guardian of _____, do hereby request

Name of minor/child

and authorize the dental staff to perform necessary dental services for my child.

Signature:_____**Date**:_____

Legal parent/guardian signature

In legal parent or guardian absence, I hereby give authorization for the person listed below to bring my child and to consent for all recommended dental/medical services.

Authorized person	Relationship to Minor/Child	Contact Number
_____	_____	_____