Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Welcome

Date ____________

Patient Information (Confidential)

Prefers to be Called ____________

Name ____________

SS#/SIN ____________ Birthdate ____________ Home Phone ____________

Address ____________ City ____________ State/ Prov. ____________ Zip/ P.C. ____________

Email ____________ Cell Phone ____________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College ____________ City ____________ State/ Prov. ____________ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ____________ Work Phone ____________

Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Email ____________ Cell Phone ____________

Driver's License # ____________ Birthdate ____________ Fax Phone ____________

Employer ____________ Work Phone ____________ SS#/SIN ____________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________

Name of Employer ____________ Work Phone ____________

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State/ Prov. ____________ Zip/ P.C. ____________

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________

Name of Employer ____________ Work Phone ____________

Insurance Company ____________ Group # ____________ State/ Zip/ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State/ Prov. ____________ Zip/ P.C. ____________

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Exam ________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐

If yes, please explain ______________________

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? ______________________

	Yes	No
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates (osteoporosis medications)?	☐	☐
5. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐

8. Are you allergic to or have you had any reactions to any medications? If yes, please list ______________________

	Yes	No
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
10. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you taking birth control?	☐	☐

6. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Diseases	☐	☐	Cancer	☐	☐	Tuberculosis	☐	☐
Heart Attack	☐	☐	AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Radiation Therapy	☐	☐
Rheumatic Fever	☐	☐	Thyroid Problem	☐	☐	Joint Replacement or Implant	☐	☐	Glaucoma	☐	☐
Swollen Ankles	☐	☐	Heart Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss	☐	☐
Fainting/Seizures	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Transmitted Disease	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Stomach Troubles/Ulcers	☐	☐	Heart Trouble	☐	☐
Low Blood Pressure	☐	☐	Angina	☐	☐	Chest Pains	☐	☐	Respiratory Problems	☐	☐
Epilepsy/Convulsions	☐	☐	Frequently Tired	☐	☐	Easily Winded	☐	☐	Mitral Valve Prolapse	☐	☐
Leukemia	☐	☐	Anemia	☐	☐	Stroke	☐	☐	Other	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Hay Fever/Allergies	☐	☐			

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you ever had any prolonged bleeding following extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15. Would you like to change the way your teeth look?	☐	☐
16. Do you like your smile?	☐	☐
17. Have you ever had Periodontal Surgery?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________________

Signature of patient (or parent/guardian if minor)

Doctor's Comments ______________________

Signature ______________________ Date ________

INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

Part of having an excellent relationship with your dental team is open and honest discussion about your treatment options. We welcome all questions about your dental health. You, the patient, have the right to accept or reject dental treatment recommendations by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment which also has risks. The following information is not meant to cause anxiety, but is part of our commitment to having excellent relationships with our patients.

Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment or that you will not experience a complication or less than optimal results. Even though many of these complications are rare, they can and do occur occasionally. If you do not understand or are concerned about any of the following information, please bring your concern up to any of our team members. Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment.
2. Root canal treatment may be needed after any restorative care.
3. Infection in need of medications, follow-up procedures, or other treatment.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition which may result in tooth loss. Although we strive for high quality dental work, even quality dental work has failures. We cannot guarantee any dental work. Sometimes teeth break, crack, crowns come loose, teeth become loose and have to be extracted.
6. The need for replacement of restorations, implants, or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment or consultation by a specialist. This can include long term chronic pain to the jaw joint, commonly known as TMJ.
9. A root tip bony fragment or a piece of a dental instrument may be left in your body and may have to be removed at a later time if symptoms develop. A root tip is most commonly associated with extraction. Crowns or other instrument pieces can be swallowed or inhaled into the lungs accidentally.
10. Jaw fracture; most commonly associated with extractions.
11. If upper teeth are treated, there is a chance of sinus infections or opening between the mouth and sinus cavity resulting in infection or the need for further treatment: most commonly associated with extraction.
12. Allergic reaction to anesthetic or medication, especially to antibiotics.
13. Need for follow-up care and treatment, including surgery.
14. It is rare for patients to experience numbness of the lip and tongue after local anesthesia has worn off. However, certain procedures may lead to prolonged numbness. These include bone surgery and extractions, more so with wisdom teeth. Any time a mandibular block is given, the nerve may be bruised, and in most cases, will take time to heal.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist. Please call our office during regular office hours to speak with a team member. Dr. Hayman can be reached after hours by cell phone at 269-580-2195.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult your physician before relying on oral birth control medication if your dentist prescribes or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before beginning treatment.

Patient Signature: ______________________________ Date: __________

Patient Signature: ______________________________ Date: __________

Patient Signature: ______________________________ Date: __________

Patient Signature: ______________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________