NOW DENTISTRY

Patient Information

Adult/Child Date: _ _ _ _ _ _

Last Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Male/Female: _ _ _ _ _

First Name: _ _ _ _ _ _ _ _ MI: _ _ _ Email: _ _ _ _ _ _ _ _ _ _ _

Birthdate: _ _/_ _/_ _ _ _ Marital Status. Single/Married/ Divorce/Widower

Driver's License #: _ _ _ _ _ _ _ _ _ _ _ _ _ #SS: _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Apt./Condo # _ _ _ _ _ _ _

City: _ _ _ _ _ _ _ _ _ State: _ _ _ _ _ Zip: _ _ _ _ _ _ _ _ _

Home Phone: _ _ _ _ _ _ _ Cell Phone: _ _ _ _ _ _ _ _ _ _ _ _

Occupation: _ _ _ _ _ _ _ Work Phone: _ _ _ _ _ _ _ _ _ _ _ _

When and where are the best times to contact you? _ _ _ _ _ _ _ _ _ _

Guarantor

If the patient is a minor, do you have legal custody? Yes/No

☐ Spouse ☐ Parent or Tutor ☐ Legal Guardian ☐ Other:

Last Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Male/Female: _ _ _ _ _

First Name: _ _ _ _ _ _ _ _ MI: _ _ _ Email: _ _ _ _ _ _ _ _ _ _ _

Birthdate: _ _/_ _/_ _ _ _ Marital Status. Single/Married/ Divorce/Widower

Driver's License #: _ _ _ _ _ _ _ _ _ _ _ _ _ #SS: _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Apt./Condo # _ _ _ _ _ _ _

City: _ _ _ _ _ _ _ _ _ State: _ _ _ _ _ Zip: _ _ _ _ _ _ _ _ _

Home Phone: _ _ _ _ _ _ _ Cell Phone: _ _ _ _ _ _ _ _ _ _ _ _

Occupation: _ _ _ _ _ _ _ Work Phone: _ _ _ _ _ _ _ _ _ _ _ _

When and where are the best times to contact you? _ _ _ _ _ _ _ _ _ _

In case of an emergency, please provide following information:

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Relationship: _ _ _ _ _ _

Work Phone: _ _ _ _ _ _ _ _ _ _ _ _ _ _ Home Phone: _ _ _ _ _ _

How did you hear about us?

☐ Yellow Pages ☐ Internet ☐ Other _ _ _ _ _ _ _ _ _ _

☐ Referral ☐ Flyer/Mail _ _ _ _ _ _ _ _ _ _

☐ Event ☐ Outside Sign/Balloon _ _ _ _ _ _ _ _ _ _

☐ Radio ☐ Cell Phone _ _ _ _ _ _ _ _ _ _

☐ TV ☐ My Insurance Plan _ _ _ _ _ _ _ _ _ _

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein

Initials: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _

Doctor's comments: _

UPDATE

Comments: _

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _

Comments: _

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _

Payment Options

☐ Insurance ☐ Now Dentistry Dental Plan

☐ Cash/Check ☐ Credit Card / Debit Card

☐ I am interested in applying for Care Credit

Dental History

Why have you come to the dentist today? _ _ _ _ _ _ _ _ _ _ _ _ _ _

Are you currently in pain? Yes / No

Have you ever had a problem with any previous dental work? Yes / No

Do your gums bleed? Yes / No

How many times a week do you brush? _ _ _ _ _ _ Floss ? _ _ _ _ _ _

Medical History

Personal physicians name:

Phone #: _ _ _ _ _ _ _ _ _ _ _ _ Date of Last visit : _ _ _ _ _ _

Your current physical health is: Good / Regular / Poor

Are you currently under the care of a physician? Yes / No

Please explain: _

Are you taking any prescription / over the counter drugs? Yes / No

Lease list each one: _

_ _

Do you smoke tobacco in any way? Yes / No

Have you ever had any of the following diseases or medical problems (please circle)

Abnormal bleeding	Epilepsy	Lupus
AIDS, HIV+	Fainting Spells	Mitral Valveprolapse
Alcohol or drug abuse	Frequent Headaches	Pacemaker
Anemia	Glaucoma	Psychiatric Problems
Arthrits	Hay fever	Radiation Treatment
Artificial Bones	Heart Attack	Rheumatic; Scarlet
Artificial Joints	Heart Surgery	Fever
Artificial valves	Heart murmur	Selzures
Asthma	Hemophilia	Shingles
Blood transfusion	Hepatits	Sickle cell disease
Cancer, Chemotherapy	Herpes, Fever blisters	Traits
Colitis	High blood pressure	Sinus Problems
Congenital heart	Hospitalized	Stroke
Defect	Kidney problems	Thyroid Problem
Diabetes	Liver disease	Tuberculosis
Difficulty breathing	Blood Pressure	Ulcers

Are you allergic to any of the following?

Aspirin	Codeine	Dental Anesthetics	Penicillin
Erythromycin	Latex	Jewelry	Tetracycline

List any patient medical condition (s): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

FOR WOMEN

Are you taking birth control pills? Yes / No

Are you pregnant? Yes / No Week # _ _ _ _ Are you nursing? Yes / No

Agreement

I acknowledge that this information is correct and will be held in the strictest confidence. I authorize Now Dentistry to contact me regarding promotions and services. I authorize Now Dentistry to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to Now Dentistry of the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I also understand that while visiting Now Dentistry, I will be videotaped and recorded by video cameras

Signature : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _

NOW DENTISTRY

INFORMED CONSENT
GENERAL DENTISTRY

Chart # _ _ _ _ _ _ _ _ _ _ _ _ _

All patients complete 1 thru 4 below, and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials_ _ _ _ _)

2. DRUGS, MEDICATION AND SEDATION

SEDATION I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased using alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking. The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment and consult with your dentist or pediatrician as needed

(Initials_ _ _ _ _)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary

(Initials_ _ _ _ _)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility

(Initials_ _ _ _ _)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials_ _ _ _ _)

6. FILLINGS

FILLINGS I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. understand that sensitivity is a common after effect of a newly placed filling.

(Initials_ _ _ _ _)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility

(Initials_ _ _ _ _)

8. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials_ _ _ _ _)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials_ _ _ _ _)

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c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials_ _ _ _ _)

DENTURES COMPLETE OR PARTIAL I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials_ _ _ _ _)

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost despite all efforts to save it.

(Initials_ _ _ _ _)

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials_ _ _ _ _)

.11. IMPLANTS

I understand that no dentistry is permanent, and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials_ _ _ _ _)

12. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment. I also understand that any dental treatment rendered that is not paid by my dental insurance company is my patient responsibility. I understand that the Treatment Plan I received from the dental office is only an estimate based on my insurance benefits and that any procedure not paid by my insurance is my responsibility.

(Initials_ _ _ _ _)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature:- Date: -

Doctor - Date: -

NOW DENTISTRY

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law, The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_ _

_ _

_ _

This consent was signed by: _

(PRINT NAME PLEASE)

Signature: _ Date: _

Witness _ Date: _

NOW DENTISTRY

PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and our staff safe and healthy.

Have you traveled outside the United States in the past 10 days? YES NO

If yes, where? _____

Have you traveled to a US City/State with reported cases of COVID 19 in the past 10 days? YES NO

If yes, where? _____

IN THE LAST 48 HOURS Have you been in personal contact with a person infected with COVID-19 or who has traveled to an area with widespread and ongoing transmission of COVID-19? YES NO

IN THE LAST 48 HOURS

Have you had a fever (99.5ºF +) YES NO

Have you experienced any of the following symptoms?

Fatigue	YES NO
New onset Headache	YES NO
Coughing	YES NO
Congestion	YES NO
Loss of smell or taste	YES NO
Sore Throat	YES NO
Difficulty Breathing	YES NO
Muscle Aches	YES NO
Nausea or vomiting	YES NO
Diarrhea	YES NO

Patient Name _____

Signature: _____ Date: _____

PLEASE RETURN TO THE FRONT DESK WHEN COMPLETED