The Dentists on Pearl

Name_____ Date of Birth _____
(if under 18, parent/guidance name)

Child's Name _____ Date of Birth _____
(if applicable)

Social Security No _____ Marital Status _____ Gender _____

Home Address _____
Street Town State Zip

Home Phone _____ Cell Phone_____

Work Phone _____ Email _____

Employer _____ Occupation _____

Insurance Company _____ Group #_____

Subscriber # _____ Policy Holder _____

Secondary Insurance Y/N? _____

Emergency Contact Information _____
Name Phone #

Who referred you to us? _____

HIPAA Consent

I acknowledge that I have received and read a copy of The Dentists on Pearl's Notice of Privacy Practices.
We may communicate with you through mail, secure email, and telephone, including leaving a message on your answering machine/voicemail.
If you give permission for us to communicate with anyone else, please list below:

NAME	PHONE	RELATIONSHIP
1.		
2.		

Signature _____ Date _____

The Dentists on Pearl

Consent for Dental Treatment

1. I authorize the personnel of The Dentists on Pearl to perform and assist in my dental treatment. Including, but not limited to examinations, preventative services, diagnostics, basic restorative, crowns, endodontic procedures, and local anesthesia and extractions.

2. I understand that dental treatment and procedures involve a variety of treatment alternatives and that each choice, including having no treatment, has certain risks. Risks may include tooth breakage or loss, swelling and infections, periodontal disease, and post treatment discomfort.

3. I understand that, during treatment, unforeseen conditions may arise and it may be necessary to change or add procedures that the dentists believes to be reasonably necessary as a result of unforeseen events that were not discovered during examination.

4. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

5. I certify that I have read and fully understand this consent for treatment. I understand that I may refuse to consent to any and all treatments or procedures that may be proposed.

_____

Patient Signature Date

Dental History

What brought you to our office today? _____

Any areas in your mouth sensitive or painful? _____

Do your gums bleed? _____

Do you have issues with your Temporomandibular Joint (TMJ) including pain, limited opening, locking or noises? _____

Do you snore or have you ever been diagnosed with sleep apnea? _____

Is there anything you would change about your smile?_____

Do you have any dental anxiety? _____

Use or history of using alcohol and/or tobacco? _____