Madeline Utterback
D.M.D., F.A.G.D.
General, Cosmetic and Implant Dentistry

PATIENT INFORMATION

Name_____ Date: _____
Last First Middle (Preferred Name)

Male Female Single Married Divorced Widowed Child Other

Date of Birth_____ Social Security # _____ Driver License # _____

Address_____Apt_____City_____ State_____Zip_____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Email Address_____Referred by _____

Employer Name_____ Occupation_____
Full time college students, please indicate name of school

Address_____Apt____City_____ State_____Zip_____

Phone ( )_____

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name_____Relationship with patient_____
Last First Middle (Preferred Name)

Male Female Single Married Divorced Widowed Child Other

Date of Birth_____ Social Security # _____ Driver License # _____

Address_____Apt_____City_____ State_____Zip_____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: (if applicable)

Insurance Name_____ ID #_____ Group #_____

Address_____Telephone #_____

Insured's Name_____Insured's SS #_____ Insured's Birthdate_____

Insured's Employer_____ Telephone # _____

Secondary Dental Insurance: (if applicable)

Insurance Name_____ ID #_____ Group #_____

Address_____Telephone #_____

Insured's Name_____Insured's SS #_____ Insured's Birthdate_____

Insured's Employer_____ Telephone # _____

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Thank you for choosing our office for your dental care needs. Our primary mission is to deliver high quality oral care with compassion, careful attention and deep personal respect.

We promise:

- To focus on you. We schedule only one appointment at a time so there is no double booking. Our staff is trained to bring you the best possible dental care.
- To be honest. We only recommend treatment for our patients that we would have ourselves.
- To be respectful. We base our success on the quality of the relationship we have with each patient, not just the quality of the dental service we provide.
- To be responsible. We use only the best materials and dental labs. Our instruments go through sterilization in a steam autoclave that is tested regularly. All services are rendered with the latest techniques available reflecting our commitment to continuing education courses. We also recycle in order to be gentle to our environment.

We know that your time is valuable and we strive to be on time and keep any waiting to a minimum. In return we require a 48 hour notice in the event you cannot keep your appointment. Failure to do so can result in a minimum $50.00 fee to your account.

AUTHORIZATION

I hereby authorize payment directly to Dr. Madeline Utterback of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. Any and all appeals to insurance will be handled by me. Non insurance payments are due at the time of service. I hereby authorize Dr. Madeline Utterback to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and my health history are correct to the best of my knowledge. I grant to this practice the right to release my records/health history and information about my dental treatment to third party payers and/or other health professionals by any method including electronic transfer.

Patient or Responsible Party Signature_____ **Date**_____

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DENTAL AND HEALTH INFORMATION

Patient Name_____ Date_____

It is important that we know about your dental and health history. Many conditions have a direct bearing on your oral health. We will review the questionnaire and discuss it with you. Information which you give us is strictly confidential and will not be released without your permission. Thank you for your cooperation.

DENTAL INFORMATION

Please describe any specific dental problem or discomfort you are having at this time: _____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery_____
"Braces" or any type of orthodontic treatment_____
Any other type of oral surgery_____

Date of Last Dental Examination:_____ Previous Dentist: _____

Have you ever had a serious injury to your face, head or teeth? _____Yes _____No
If yes, please explain:_____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

_____ Sensitive Teeth to cold, hot, sweet, or biting
_____ An unpleasant taste or persistent bad breath
_____ Does food catch between your teeth
_____ Do your gums bleed when brushing
_____ Red, swollen, tender, bleeding, or sore gums
_____ Gums that have pulled away from the teeth
_____ Pus between the teeth and gums
_____ Avoid any area when brushing or chewing
_____ You clench or grind your teeth
_____ A Clicking, snapping or difficulty when chewing
_____ Difficulty opening or moving the jaws
_____ Difficulty speaking or changes in your voice
_____ Difficulty moving your tongue or "tongue tied"
_____ Loose or separating teeth
_____ Changes in the way your teeth fit together
_____ A color change of the tissues in your mouth
_____ Any lumps, swelling or swollen glands
_____ Sores, ulcers, or rough spots in your mouth

Do you Smoke?	_____Yes	_____No
Do you consume alcohol?	_____Yes	_____No
Do you gag easily?	_____Yes	_____No
Do you snore?	_____Yes	_____No
Do you feel your teeth could be whiter?	_____Yes	_____No
Have you experienced waking up choking?	_____Yes	_____No

Please share with us anything that will help us to make you more comfortable during your dental appointment, including any special needs

_____

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HEALTH INFORMATION

How do you rate your overall health? Good Fair Poor

Primary Physician: _____ Phone: _____ City:_____
Date of last physical examination:_____

Other Physicians & Specialist
Name: _____ Specialty: _____ Phone: _____ City: _____
Name: _____ Specialty: _____ Phone: _____ City: _____

1. Within the last 3 years, have you been hospitalized or had surgery? Yes No
If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointment? Yes No

3. Are you taking any drugs, medications, or treatments at this time? Yes No
(If you have a complete written list with you, give that to the receptionist instead)

Prescribed: _____
_____
Over the Counter (OTC) medications (such as Aspirin, Advil, allergy medication, etc.):
_____
Vitamins, natural or herbal preparations and/or dietary supplements:
_____

4. Are you taking or have you ever taken Fosamax? Yes No

5. Are you allergic to or have you ever experienced an unusual reaction to:
_____Latex _____Metals or jewelry _____Dental anesthesia (local)
_____Fluoride _____Nitrous oxide (laughing gas) _____General anesthesia

6. Are you allergic to or have you ever had any reactions to any of the following drugs?
_____Penicillin (or related drugs) _____Tranquilizers (Valium) _____Tetra cycline
_____Aspirin / Ibuprofen (Advil, Motrin, Nuprin) _____Keflex (Cephalexin) _____Sulfa drugs
_____NSAID (Celebrex, Vioxx, Anaprox) _____Clindamycin (Cleocin) _____Erythromycin
_____Codeine _____Iodine

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? Yes No
If yes, please list: _____

Continued on next page…

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8. Do you have, or have you ever had, any of the following? (Please check what applies)

_____Congenital heart defects
_____Angina or chest pains
_____Atherosclerosis
_____Congestive heart failure
_____Coronary artery disease
_____Heart surgery, type & date_____
_____Heart attack, date_____
_____Rheumatic heart disease / rheumatic fever
_____Infective Endocarditis
_____Heart valve(s) damage / Mitral valve prolapsed
_____Artificial heart valve
_____Pacemaker
_____Stroke or CVA
_____High Blood Pressure
_____Low Blood Pressure
_____Anemia
_____Hemophilia or Bleeding disorder
_____Excessive bleeding from any cut or incident
_____Diabetes or blood sugar problems
_____Any artificial joint, joint surgery, or prosthesis
If yes, what joint or area: _____
When was operation done: _____
_____Hepatitis, jaundice, or other liver problems
_____Any form of cancer
_____An organ transplant
_____Asthma
_____Hay fever, skin or food allergies or allergies in general
_____Sinus problems
_____Tuberculosis, emphysema or lung disorder
_____Skin problems
_____A sore or wound that bleeds easily or does not heal
_____A Thyroid problem or disease
_____Arthritis
_____Glaucoma or any eye diseases
_____Epilepsy or other seizure disorder
_____Any kidney problems
_____Ulcers, acid reflux, or stomach problems
_____A compromised immune system (Lupus, HIV, AIDS, etc.)
_____Multiple sclerosis
_____Cerebral palsy
_____An active sexually transmitted disease (STD)
_____Any mental health issues
_____Been treated for any psychiatric condition

Women Only:
_____Are you pregnant, due date: _____
_____Do you think you might be pregnant
_____Are you presently nursing
_____Are you using birth control medication
_____Are you taking hormone replacement therapy

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No If Yes, please explain:_____
_____
_____

Consent – To the best of knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Patient or Responsible Party Signature_____ **Date**_____

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HIPPA PATIENT CONSENT FORM

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Dr. Madeline Utterback may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Dr. Madeline Utterback has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practices. If you have any questions, please contact our HIPAA Compliance Officer: Dr Madeline Utterback.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and Indirectly Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dental certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the above address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient or Responsible Party Name: _____

Patient or Responsible Party Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information. We may use and disclose your medical/dental records only for each of the following purposes: treatment, payment, and health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be working with a specialist such as an oral surgeon.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim to your insurance company for payment. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending financial information to an accountant for auditing and tax purposes.

We may also create and distribute de-identified health information by removing all references to individually identifiable information such as name, phone numbers, etc. We may contact you to provide appointments or information about treatment options or other health–related benefits and services that may interest you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a request to this office:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. However, if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.