

Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please Print)

Rick Redmond Family Dentistry

101 So. Douglas Ave. (P.O. Box 1125) • Sylacauga, AL 35150 • 256-245-3645

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

PATIENT LAST NAME: _____ FIRST: _____ MIDDLE: _____

Name/Nickname you prefer to be called by: _____ DOB: _____

Minor Single Married Separated Divorced Widowed Male Female

Full Time Student? Yes No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Social Security Number _____

How did you hear about our practice? _____ Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Social Security Number _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Social Security Number _____

NEAREST RELATIVE (Not living with you) (For Emergency Contact)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

YOUR PREFERENCES

Do you prefer appointment reminders by: Email Phone Text

Do you prefer to receive calls from our office at: Home Work Cell

PLEASE COMPLETE INSURANCE SECTION ON REVERSE SIDE OF THIS FORM

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____ GR #: _____	

Secondary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____ GR #: _____	

Medical Insurance Information

Primary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____ GR #: _____	

Secondary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____ GR #: _____	

Authorization

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part of my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

A. RICK REDMOND FAMILY DENTISTRY

MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions:

ALLERGIES

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

ENDOCRINE

Diabetes	Y	N
Gout	Y	N
Thyroid Problems	Y	N

EYES, EARS, NOSE & THROAT

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

GASTROINTESTINAL

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

GENTOURINARY

Frequent Urination	Y	N
Kidney Disease	Y	N
Nocturia	Y	N

GENERAL

Cancer	Y	N
Chemotherapy	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N

HEMATOLOGICAL

Bleeding Problems	Y	N
Hepatitis	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Arthritis	Y	N
Joint Pain	Y	N

ORAL

Have you taken bone loss prevention drugs such as Fosomax, Actonel, Boniva or other bisphosphonates? Y N

Do you take or need antibiotics before dental procedures? Y N

WOMEN ONLY

Are you pregnant?	Y	N
Are you nursing?	Y	N
Are you taking Oral Contraceptives	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N
Epilepsy	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Shortness of Breath	Y	N
Emphysema	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP? How Often? _____	Y	N
Has anyone told you that you snore?	Y	N

SOCIAL HISTORY

Do you smoke	N	Y	_____Packs a day
Do you use smokeless tobacco	Y	N	

MEDICAL HISTORY and CONSENT

List any medications you are taking:

List any surgeries and hospitalizations you have had:

Medications	Dosage/Freq.	Prescriber	Reason	Date (Year)	Surgery	Surgeon	Reason
1. _____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____

List and detail any medical condition not listed above:

Primary Physician's Name: _____ Physician's Phone(_____) _____

Are you under the care of other physician's? If so, please list:

Physician	Phone #	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes **A. Rick Redmond, DMD** to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize **A. Rick Redmond, DMD** to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that **A. Rick Redmond, DMD** choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by **A. Rick Redmond, DMD**. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1-1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize **A. Rick Redmond, DMD** and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient _____ Date _____

Signature of Patient _____

Consent (for a minor child):

Name of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices, policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

Date _____

Signature of Patient _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care, please complete this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ ZIP _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where _____

Do you:.....

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance Yes No

Would you like to replace your silver fillings? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

Please describe _____

Have you ever had and upsetting dental experience? Yes No

Please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____