TIME 03:53 PM DATE 2/28/2018

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Dental Associates Medical History Updated: 11/07/2017

Patient Name: Birth Date: Date Created:

Disclaimer

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

General Single Questions

Question	Answer	
Are you under a physician's care now?	Yes No	
Have you ever been hospitalized or had a major operation?	Yes No	
Have you ever had a serious head or neck injury?	Yes No	
Are you taking any medications? Including blood thinners or aspirin?	Yes No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
When was your last complete physical exam?		
Have you ever been diagnosed and/or treated for chronic pain?	Yes No	
Prosthetic Joint Replacement? If yes, provide date replaced, doctor's name and number, and if premedication?	Yes No	If yes
Diagnosed Heart Conditons? If yes, provide doctor's name and number, and if you need premedication.	Yes No	If yes
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	

Current Health

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Herpes	Yes No
High Blood Pressure	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Shingles	Yes No	Artificial Joint	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Sinus Trouble	Yes No	Frequent Cough	Yes No
Kidney Problems	Yes No	Leukemia	Yes No	Breathing Problems	Yes No	Liver Disease	Yes No
Stroke	Yes No	Low Blood Pressure	Yes No	Cancer	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No
Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No
Heart Pacemaker	Yes No	Ulcers	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No
Cardiac Pacemakers	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

General List Questions

Women: Are you...

- [ ] Pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?
- [ ] Menopause?
- [ ] Trying to get pregnant?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics/Novacaine
- [ ] Ibuprofen

Other? [ ] If yes

Oral Hygiene

What type of toothbrush do you use?

- ☐ Soft
- ☐ Medium
- ☐ Hard

Do you use a manual or electric toothbrush?

- ☐ Manual
- ☐ Electric

How often do you brush your teeth?		Comment	
How often do you floss your teeth?		Comment	
Do your gums ever bleed when you brush?		Comment	
How long since you have been to a dentist?		Comment	
Reason for appointment		Comment	
Do you have any dental complaints at this time?		Comment	
Do you have any growths or sore spots in your mouth that have lasted more than 1 week?		Comment	
Do you suffer from recurrent headaches or pain in your jaw?		Comment	

Medications

Emergency Contact

Person to contact in case of an emergency (Name and Phone Number)

Due to the new Federal government patient confidentiality regulations, the office will need your permission to do the following:

1. Use or disclose your health information for treatment, payment, and healthcare provider providing treatment to you.
2. Use or disclose your healthcare information to a healthcare provider providing treatment to you.
3. Contact a family member, or friend to help with your healthcare.
4. Disclose healthcare informaiton when required to do so by law or national security.
5. Contact you with appointment reminders such as phone calls, postcards, emails, letters, answering machines, voice mail and leaving messages with family members or friends.

Signature of Patient, Parent or Guardian:

X Date:___________

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________

BRIAN W. MUHLER, D.D.S., P.A.
R. D. Martin, D.D.S.
G. H. Bui, D.D.S.
M. S. Sugar, D.D.S.

DENTAL TREATMENT CONSENT FORM

Dentist's Name: ________________________ **Patient's Name:** ____________________________ Please be sure to read the following items below, and sign / date second page of this form.

1. **DENTAL PROPHYLAXIS, FLOURIDE TREATMENT AND RADIOGRAPHS**

I understand that dental prophylaxis involves cleaning the teeth, including removal of plaque, calculus and extrinsic stains, above and below the gums with hand scaling, ultrasonic scaling instruments and hand or electric polishers. This can cause gum soreness and tooth sensitivity. When fluoride / varnish treatment is indicated, the use of topical fluoride can cause nausea if ingested. When indicated, taking dental radiographs involves the use of X-Ray equipment (radiation)-precautions are taken to protect the patients including the use of the lead apron with a thyroid collar.

2. **DRUGS AND MEDICATIONS**

I 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).

3. **CHANGE 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.

4. **EXTRACTION OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and 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, sinus exposure, loss of feeling in my teeth, lips, tongue, and surrounding tissues(Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand 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.

5. **CROWNS, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I 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 the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

2 GREENMEADOW DRIVE
TIMONIUM, MD 21093
TEL: 410-252-2424 FAX: 410-252-9026

Revision August 15, 2019

6. DENTURES, COMPLETE OR PARTIAL

I realize that immediate, full, or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, and possible breakage. I understand wearing dentures is difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. I understand that most dentures require relining approximately 3 to 12 months after the initial placement. In the case of immediate dentures, several relines and considerable adjusting may be required, as well as a permanent reline. A new denture may need to be made due to the estimation of an immediate denture; I understand that the additional cost is my responsibility. I understand that the cost of any reline is not included in the initial denture fees. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be at the "teeth in wax" try-in visit. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

7. ENDONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

8. PERIDONTAL LOSS (TISSUE & BONE)

I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.

9. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling may be required, that was not initially diagnosed, due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. I understand that root canal therapy may be needed following a restorative procedure, if the tooth becomes sensitive.

10. IMPLANTS

I understand the risks of nerve damage or sinus perforation. I understand the risk of failure of the implant. If failure of the implant occurs due to improper post care, smoking or diabetes, I understand that there will be no reimbursement.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient____
Date___________________________________

Signature of Parent/Guardian if patient is a minor _________________________