Kent Nuttall, DMD

DENTAL CARE FOR A LONG LIFE OF SMILES

We would like to get to know you better!

Name____ SS# __________________________ ☐ Male ☐ Female

Address ____ City ____________________________ State ________ Zip __________

Home Phone_________________________ Work Phone __________________________ Cell Phone _________________________

Email Address ____ Date of Birth ___________________________

Occupation ____ Employer____

Parent or Spouse's Name ____ Their Phone # _________________________

Who may we thank for referring you? ____

Person to contact in case of emergency____ Phone _________________________

Person responsible for dental investment ____

For dependents 18 years and older that are covered under parents insurance, we will need their student status for insurance processing.

Student Status: Full Time Total Semester Hours: ___________________ Part Time Total Semester Hours__________________________

For Insurance Purposes:

Name of Policy Holder___________________________Date of Birth _______________________ Relationship to Patient __________

SS# ___________________________ Member ID____________ Employer____

Insurance Company____

Insurance Company Phone # __________________________ Group Number ____

Consent For Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents or medication carries certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information is necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Financial Information

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or his staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand payment for service is due at the time they are performed.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that the payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment is made.

I understand that if I am unable to keep my appointment, there will be a $75 charge if 24 hours notice is not given.

Patient Signature____ Date __________________________

Patient Name ______________________________ Date ______________

Medical History

- Please circle Y for "Yes" or N for "No" for any of the following which may apply to you now or in the past

Y **N** Heart attack or Heart Trouble
Y **N** Congenital Heart Disease
Y **N** Chest pain with exercise (Angina)
Y **N** High Blood Pressure
Y **N** Heart Valve Disorder
Y **N** Pacemaker
Y **N** Implants or Artificial Joint When? ______________
Y **N** Anemia or Blood Disorder
Y **N** Excessive Bleeding
Y **N** Diabetes Recent A-1-C? ______________
Y **N** Stroke When? ______________
Y **N** Thyroid Disease
Y **N** Athsma
Y **N** HPV

Y **N** Ulcers, Reflux or Heartburn
Y **N** Digestive Disorders
Y **N** Kidney Problems
Y **N** Fainting or Blackouts
Y **N** Headaches or Migraines
Y **N** Epilepsy or Seizures
Y **N** Tumors, Cancer, Radiation Treatment
Y **N** Tuberculosis, Lung Problems
Y **N** Hepatitis A B C D
Y **N** AIDS or HIV Infection
Y **N** Psychiatric Disorders
Y **N** Use Tobacco? How much? ______________
Y **N** Drug / Alcohol Dependency
Y **N** Sleep Apnea

Are you currently under a physician's care? **Y** **N**
If yes, please explain ______________________________
Have you had any serious illness, operations or been hospitalized in the past 5 years?
If yes, please explain ______________________________
Has your physician recommended that you take antibiotic prior to dental treatment? **Y** **N**
Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, a sedative, aspirin, latex or metals?
If yes, please explain ______________________________
Is there anything else you would like us to know about your health? ______________________________
What prescription or over the counter drugs, medications, vitamins or herbs are you taking at this time?
____
____
____

Dental History

Y **N** Are you experiencing any dental discomfort?
Y **N** Is your mouth frequently dry?
Y **N** Does your jaw become sore with chewing?
Y **N** Sensitivity to: Hot / Cold / Biting Pressure?
Y **N** Do you grind your teeth?

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

Y **N** Are you interested in improving the appearance of your smile? If yes, what would you like to change? (ex: straightening, shape, color, longer teeth, less gummy) ______________________________

Y **N** Do you become nervous or anxious during dental visits?
Please rate your level of dental anxiety on a scale from 0-10 (0=None, 10=Extreme) ______________
Have you ever had any problems associated with previous dental treatment? ______________

Patient Signature ______________________________ Date ______________
Dentist / Hygienist Signature ______________________________ Date ______________

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Kent D. Nuttall, DMD, PS. The Statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted at the facility.

Kent D. Nuttall, DMD, PS reserves the right to change the privacy practices currently described in The Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mialed or otherwise transmitted to me.

Additional Disclosure Information

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Y **N** Spouse only

Y **N** Any Member of my immediate family: (Spouse, Children, Children's Children)

Y **N** Any Member of my extended family: (Parents, Grandchildren)

Y **N** Other ______________________________

Name of Patient (please print) ______________________________

Patient Signature ______________________________

Patient's Personal Representative (please print) ______________________________

Personal Representative's Signature ______________________________

Representative's Telephone Number ______________________ Date ______________________

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Y **N** Provided Prior to Treatment? Date Statement Provided ______________________________

Reason for not obtaining patient signature:

- ☐ Needed more time to review Statement
- ☐ Wanted to consult another person before signing
- ☐ Physically unable to sign
- ☐ No reason offered.
- ☐ Other ______________________________

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