James S. Nelson, D.D.S. P.C.

1611 Sheridan Lake Rd. • Rapid City, SD 57702

605-341-3670

WELCOME TO OUR PRACTICE

Chart # _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc.) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ SS# _____ - _____ - _____ Previous Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) ___ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip)

Please Enter Employer and Occupation:

_____

_____

Whom may we thank for referring you to our practice?

_____

In am emergency, who should be notified? Please enter Name and Phone number below:

_____

RESPONSIBLE PARTY INFORMATION

Please enter information for the personal financially responsible for the account.
If the Patient is the responsible party, please skip this section and continue to the next section.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither – not applicable

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc.) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ SS# _____ - _____ - _____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) ___ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip)

DENTAL INSURANCE

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc.

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ _____
City State Zip

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____
City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ _____
City State Zip

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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MEDICAL HISTORY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med – Amoxicillin
- ☐ *Pre-Med – Clindamycin
- ☐ *Pre-Med – Other
- ☐ Allergies (see addt'l question)
- ☐ Allergy – Aspirin
- ☐ Allergy – Codeine
- ☐ Allergy – Erythromycin
- ☐ Allergy – Hay Fever
- ☐ Allergy – Latex
- ☐ Allergy – Other
- ☐ Allergy – Penicillin/Amoxicillin
- ☐ Allergy – Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure – High
- ☐ Blood Pressure – Low
- ☐ Cancer
- ☐ Chemotherapy/Radiation
- ☐ Diabetes – Type 1
- ☐ Diabetes – Type 2
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Mital Valve Prolapse
- ☐ Artificial Heart Valves
- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Damaged Heart Valves
- ☐ Heart Attack
- ☐ Congenital Heart Defects
- ☐ Abnormal Bleeding
- ☐ Blood Transfusion
  If yes, date: _____
- ☐ Hemophilia
- ☐ Autoimmune Disease
- ☐ HIV
- ☐ AIDS
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematosus
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chest Pain Upon Exertion
- ☐ Chronic Pain
- ☐ Eating Disorder
- ☐ Malnutrition
- ☐ Gastrointestinal Disease
- ☐ G.E. Reflux/Persistent Heartburn
- ☐ Thyroid Problems
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Neurological Disorders
  If yes, specify: _____
- ☐ Sleep Disorder
- ☐ Recurrent Infections
- ☐ Osteoporosis
- ☐ Persistent Swollen Neck Glands
- ☐ Severe Headaches/Migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted disease
- ☐ Excessive urination
- ☐ Subject to frequent headaches
- ☐ FEMALE: Pregnant or Planning Pregnancy

☐ Tobacco Use If so, what kind and how much/often? _____

☐ Alcohol Use If so, what kind and how much/often? _____

If any of the conditions or alerts above need further clarification, please describe: _____

_____

_____

_____

_____

_____

_____

Do you have any disease, condition, or problem not listed above that you think the dentist should know about? ☐ Yes ☐ No

_____

_____

_____

MEDICAL HISTORY

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? If yes, please explain below.* ☐ Yes ☐ No

_____

_____

Are you taking any medications *(prescription and non-prescription)* including regular doses of aspirin or birth control pills? If yes, please list below.*

☐ Yes ☐ No

Medications & Doses: _____

_____

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ☐ Yes ☐ No

If yes, date treatment began: _____

Do you have any allergies *(including allergies to medications, local anesthetics, sedatives, metals, etc.)*? If yes, please explain below.* ☐ Yes ☐ No

Allergies & Type of Reaction: _____

_____

_____

Name of your Physician and Phone Number: _____

_____

Name and Phone Number of Preferred Pharmacy: _____

_____

Have you had a serious illness, operation or been hospitalized in the past 5 years or do you have any impending surgery? ☐ Yes ☐ No

If yes, what was/is the illness or problem? _____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medication conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any further changes. This will serve as my electronic signature.

Response Date: _____

DENTAL HISTORY INFORMATION

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number: _____

_____

Date of most recent dental exam and dental x-rays: _____

_____

What was done at last appointment: _____

_____

I routinely see my dentist every:

☐ 3 mos. ☐ 4 mos. ☐ 6 mos. ☐ 12 mos. ☐ Not routinely

How do you feel about your smile?_____

_____

Are you currently experiencing dental pain or discomfort? If yes, please list below.* ☐ Yes ☐ No

_____

What is the reason for your visit today? _____

_____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have or had dry mouth
- ☐ Food gets trapped between any teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Clench or grind your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Have or had gum recession
- ☐ Have or had a burning sensation in your mouth
- ☐ Would like to change the appearance of my smile
- ☐ Had trouble getting numb
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have whitened or bleached your teeth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance
- ☐ Have been treated for gum disease
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Snore or wake up frequently during the night
- ☐ Have flouridated water at my home
- ☐ Drink bottled or filtered water
  If yes, how often? Daily / Weekly / Occasionally
- ☐ Have earaches or neck pains
- ☐ Have sores or ulcers in your mouth
- ☐ Wear dentures or partials
- ☐ Participate in active recreational activities
- ☐ Had a serious injury to your head or mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

DENTAL HISTORY INFORMATION

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release that I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

_____

_____

_____

☐ * By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and or your assignee, to telephone me to discuss this statement or my treatment.

☐ * By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me, and that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to the transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws, directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR OTHER SERVICES.

☐ * I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Name of person filling out this form: *

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Response Date: _____