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APPOINTMENT:
ARRIVED:
WALK-IN:

Quad	Tooth #	Treatment Plan
Upper Right	1	
	2	
	3	
	A 4	
	B 5	
Upper Anterior	C 6	
	D 7	
	E 8	
	F 9	
	G 10	
	H 11	
Upper Left	I 12	
	J 13	
	14	
	15	
	16	
Lower Left	17	
	18	
	19	
	K 20	
	L 21	
Lower Anterior	M 22	
	N 23	
	O 24	
	P 25	
	Q 26	
	R 27	
Lower Right	S 28	
	T 29	
	30	
	31	
	32	
PROPHY		
PERIO		
PROSTHETIC		
COE/LOE/POE	BW:	PA's:
DENTAL ASSISTANT		
BLOOD PRESSURE		
NOTES		

NAME

ADDRESS **APT#**

CITY **STATE** **ZIP CODE**

HOME PHONE	**WORK PHONE**
DATE OF BIRTH	**SOCIAL SECURITY**
EXAM DATE	☐ **FEMALE** ☐ **MALE**

PATIENT SIGNATURE

EXAM BY DOCTOR

☐ MEDICAL HISTORY

☐ ALLERGY ALERT

OPERATORY

NOTES

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PATIENT INFORMATION

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____

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COMMUNICATION RELEASE FORM

Date: _____

I, _____ (insert name of patient) want **Olive Dental** to communicate with me via e-mail, phone, text, mail or other media about products or services that pertain to my conditions or that can contribute to matters related to my health and/or my medical treatment. I understand my Protected Health information may be referenced to determine that I may be a likely candidate for products or services that my dental practitioner may share with me.

Olive Dental may communicate with me about my oral health, treatment, appointments, and post-operative follow-ups by mail, e-mail, text or by phone to the contact information on file. It is my responsibility to ensure all my contact information is up to date.

I understand that communication between **Olive Dental** and I may not be encrypted and my information could be intercepted by unauthorized persons. I agree to hold **Olive Dental** harmless for any actions resulting from intercepted communications.

Olive Dental will not be responsible for any unauthorized interceptions. However, we will make reasonable measures to ensure proper delivery or notification of our patient's information. Examples include, but are not limited to, post-operative phone calls and appointment reminders.

This consent remains in effect until expressly revoked (in writing).

Name: _____

Signature: _____

Witnessed by: _____

Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this offices Notice of Privacy Practices

_____
Print

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this ptient but it could not be obtained because:

- The patient refused to sign
- Due to an emergency, it was not possible to obtain acknowledgement
- We couldn't communicate with the patient
- Other (please provide specific details)

_____
_____
_____
_____

_____ _____
Employee Signature Date

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DENTAL TREATMENT CONSENT FORM

EXAM AND X-RAYS (Initials____)

DRUGS AND MEDICATIONS (Initials____)

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).

CHANGES IN TREATMENT PLAN (Initials____)

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.

Signature of Patient_____ **Date**_____

Signature of Parent/Guardian_____ Date_____