Patient's Name: ________________________ DOB: ______________ Age: ________

Social Security #:_________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐Child ☐ Other

Home Phone: ______________ Cell Phone: ______________ Work Phone: ________________

Address:____

City: ________________State: ______________________________Zip: ____________

Employer: ______________________ Occupation: __________________ Years: __________

Email: ____________________ Primary MD: _______________ Prev Dentist: _____________

In Case of emergency, Contact: ________________Phone #: ____________Relation: __________

Subscriber Name: ______________________ Subscriber DOB: __________________________

Dental Insurance Co: ______________________ ID #: _________________ Group #: ________

Referred By: ____________________________

DENTAL HISTORY

I. Circle Appropriate Answer

1. Yes No Are you happy with your smile, and are you satisfied with the overall condition of your mouth?
   If No, what would you like to improve? ________Appearance, ____Chewing Ability _____, Pain
2. Yes No Have you experienced bleeding gums?
3. Yes No Have you experienced tender gum tissue?
4. Yes No Do you grind your teeth?
5. Yes No Do you Suffer from frequent headaches?
6. Yes No Are your jaws frequently sore?
7. Yes No Have you experienced sensitive teeth?
8. Yes No Have you experienced Sinus Problems?
9. Yes No Have you had problems with prior dental treatment?
   If Yes, what ____
10. Yes No Are you in pain now? If Yes, how long?______________________________
11. Yes No Are you sensitive to caffeine (Coffee, Tea)? ___________________________

MEDICAL HISTORY

I. Circle Appropriate Answer

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health with in the last year?
3. Yes No have you been hospitalized or had a serious illness in the last three years?
   Why? ____
4. Yes No Are you being treated by a Physician now? Why? ___________________________

II. Have you Experienced?

5. Yes No Chest Pain?
6. Yes No Shortness of Breath?
7. Yes No Recent weight loss, Without Dieting?
8. Yes No Persistent Cough, Coughing up blood?
9. Yes No Dry Mouth?

21. Yes No Excessive Thirst?
22. Yes No Frequent Urination?
23. Yes No Bleeding Problems, Bruising easy?
24. Yes No Seizures and/or epilepsy?
25. Yes No Any Immune Suppression Disorder?

II. Have you Experienced? (continued)

10. Yes No Heart Disease?
11. Yes No Tumors, Cancer?
12. Yes No Heart Murmurs/MVP?
13. Yes No Rheumatic Fever?
14. Yes No Stroke, Hardening of arteries?
15. Yes No High Blood Pressure?
16. Yes No TB, emphysema, other lung diseases?
17. Yes No Hepatitis, other Liver Diseases?
18. Yes No Kidney, bladder diseases?
19. Yes No Family History diabetes, heart problems, tumors?
20. Yes No Fainting Spells?
26. Yes No Diabetes?
27. Yes No Arthritis, Rheumatism?
28. Yes No Eye disease?
29. Yes No Skin diseases?
30. Yes No Anemia?
31. Yes No VD (Syphilis or gonorrhea)?
32. Yes No Herpes?
33. Yes No Thyroid, adrenal disease?
34. Yes No ALLERGIES
    Penicillin Latex
    Other: ____________

III. Have You Had or Are You Taking?

35. Yes No Fen/Phen or other weight loss medication?
36. Yes No Radiation treatment? Date: _____________
37. Yes No Chemotherapy?
38. Yes No Prosthetic heart Valve? Date: ___/____/___
39. Yes No Blood transfusions? Date: ____/____/____
40. Yes No Recent Hospitalization?
41. Yes No Artificial Joint?
42. Yes No Surgeries?
43. Yes No Pacemaker?
44. Yes No Psychiatric care?

IV. Are You Taking?

45. Yes No Recreational Drugs?
46. Yes No Drugs, medication (incl, Aspirin)?
47. Yes No Tobacco in any form?
48. Yes No Alcohol?

Please List all medications currently taking: ___________________________, _________________________________

_____________________________, ___________________________, _________________________________

_____________________________, ___________________________, _________________________________

49. Yes No Do you have, or have you had any other diseases or medical problems NOT listed on this form?
    If so, please explain: ____
50. Yes No Would you like to discuss anything with the doctor in confidence?
    ____

V. Women Only

51. Yes No Are you or could you be pregnant or nursing?
52. Yes No Are you taking birth control pills?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. This is to certify that I, the undersigned, consent to the performing of any treatment deemed necessary, and the use of local anesthetic or analgesia as indicated. I also understand that I am responsible for my own dental bill. My insurance company will be billed by Well Beyond Dental as a courtesy.

Patient/Guardian's Signature:____ Date________________________

Recall Review:

Patient/Guardian's Signature:____ Date________________________

Patient/Guardian's Signature:____ Date________________________

Patient/Guardian's Signature:____ Date________________________

Patient/Guardian's Signature:____ Date________________________

Financial Policy

Tamra L. Neugebauer, DDS

Thank you for choosing our practice for your dental health. Dental Treatment is an excellent investment in your physical and psychological well-being. My team and I are committed to the success of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign as part of our office policy.

______ Initial: Your insurance benefits are a contract between you and your insurance company. We Will bill your insurance for all treatment; however, your estimated patient portion is due at the time of treatment. We will send you a statement due any remaining balance not paid by your insurance.

______ Initial: For payment we accept cash, check and most major credit cards. We also offer flexible payment plans through Care Credit, and payment plans consisting of three or fewer payments in office with credit cards on file. Payment plans must be approved before treatment. A $ 30.00 fee will be applied for all returned checks.

______ Initial: The parent accompanying a minor child to the appointment is responsible for any payment due.

_______ Initial: A 50% deposit will be required at the time of the first appointment for all treatment requiring lab work. The remaining balance is due at the time the prosthesis is cemented or inserted.

_______ Initial: We require 48 hours' notice to reschedule/cancel appointments. If 2 or more appointments are missed or cancelled in a 12-month period without 48 hours' notice, a rescheduling fee of $75.00 may be applied to your account.

I have read the above Financial Policy. I understand and agree to this Financial policy.

Print Name: ____ Date: ____________________

Signature: ____

<u>HIPAA PRIVACY CONSENT FORM</u>

Dr. Tamra Neugebauer, DDS

I understand that according to the Federal Health Insurance Probability and Accountability act (HIPAA) this office is unable to discuss my diagnosis, treatment, account balance, financial agreements, or anything that may reveal my personal information.

I hereby agree/consent to allow Dr. Tamra Neugebauer and staff to discuss any pertinent information with the following individuals:

1.____

2.____

3.____

4.____

5.____

☐ Please check this box if you authorize our staff to leave a detailed message on your contact number regarding, treatment, appointment, insurance, etc.

I understand this consent will remain in effect until I replace this form with a new consent form.

Patient Name: ____

Patient Signature: ______________________________ Date: ________________

TM/AIRWAY - SLEEP SCREENING FORM

PATIENT NAME: ________________________________ **DOB:** ______________________

1. Have you ever been told that you need to wear a CPAP for Sleep? Yes No
2. Do you use over the counter medication for headache pain or sleep aid? Yes No
3. Is it easy for you to get to sleep? Yes No
4. Do you often wake? Yes No
5. Do you feel rested when you wake in the morning? Yes No
6. Do you experience sounds like popping or clicking in the jaw joints? Yes No

Patient Signature: _______________________________**Date:** ______________________

FOR CLINICAL OFFICE USE:

JVA QUICK COMPLETED: Yes No

BP: _____/_____ Open bite: ___________

OB: __________mm OJ: ________mm

Range of Motion Measurements:

Interincisal Opening (w/o pain) ______mm

Interincisal Opening (w/Pain) ______mm

Lateral Excursion Right _______mm

Lateral Excursion Left ________mm

Protrusive ________mm

By: __________________ (Initials)

Date: __________________________