Dental Wellness
of Milford

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.

We reserve the right to change our privacy practice and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. You may contact us to request more information about our privacy practices.

USES AND DISCLOSURES OF HEALTH INFORMATION:
We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician, dentist or other healthcare provider providing treatment to you.

PRINT NAME:_____

SIGNATURE:_____ **DATE:**_____

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

Dental Wellness of Milford

New Patient Information

Date:_____

Patient Name:_____
(First) (Last) (M.I.)

Preferred Name:_____ EMAIL:_____

Marital Status: Married:_____ Single:_____ DOB:_____

Patient Address: _____

Preferred Phone#: _____(Home/Cell) Other Phone#:_____

Patient S.S. #:_____

Person Responsible for Paying Account:_____ Relationship:_____

Address/Phone#: of Person Paying if Different than Above:_____

_____

Primary Insurance Co:_____ Ins Phone #:_____

Subscriber Name:_____ Subscriber DOB:_____

Claims Address:_____

Subscriber ID#:_____ Subscriber S.S.#:_____

Group #_____ Group Name#:_____

Employer:_____

Secondary Insurance if Applicable_____

Who can we thank for referring you to our practice?_____

Last Dental Visit?_____ Purpose of this visit:_____

What is most important to you in your dental health?_____

I agree to pay for all the professional fees and treatment at the time of service, or my portion not covered by dental insurance, for myself or the above named patient, unless other financial arrangements are approved. In addition, my signature on this form is my acknowledged authorization for Dr. Johnson to seek a Credit Report if credit is extended.

Signature: _____ Date:_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____

Date of most recent treatment (other than a cleaning) _____ / _____ / _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐
GUM AND BONE			
7.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11.	Have you ever experienced gum recession? _____	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years? _____	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20.	Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT			
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming more loose? _____	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	☐	☐
32.	Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34.	Have you ever whitened (bleached) your teeth? _____	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____