



Welcome



We are pleased to welcome you to our practice!

Patient Information

Patient's last: _____ First: _____ M.I.: _____ Date: _____

Birth Date: _____ Social Security # _____ Sex: _____ Family Status: Single / Married / Divorced / Child / Other

Home Phone: _____ Work: _____ Cell: _____ Other: _____

Physical Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Mailing Address (PO Box, etc.): _____ City: _____ State: _____ Zip: _____

Email Address: _____

Preferred appointment times (please circle): Morning Afternoon Evening Anytime Days (please circle): Mon Tues Wed Thurs Fri Sat

How do you prefer to be contacted? Phone: Yes No / Email: Yes No / Text Messaging: Yes No

What Pharmacy do you prefer? _____ City: _____

Emergency Contact: Name: _____ Phone: _____

Whom may we thank for referring you to our practice? _____



Dental History



Date of Last Dental Visit: _____

Why have you come to the dentist today? _____

Are you currently in pain? Y N

Have you experienced problems associated with any previous dental work? Y N

Do you now or have you ever experienced pain/ discomfort in your jaw (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you Brush Daily? Y N Floss Daily? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change? _____

Type of bristles on your brush: Hard Med Soft

Do you use anything in addition to your brush and floss? Y N
If yes, what? _____

Do your gums bleed? Y N

Have you ever had periodontal disease? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? Y N If yes, why? _____

Do you still have your wisdom teeth? Y N

Do you need to **PRE-MED** before dental work? Y N

Have you experienced the following dental problems?

Bad Breath	Y	N	Figernail biting	Y	N	Mouth Breathing	Y	N
Bleeding gums	Y	N	Food collection between teeth	Y	N	Mouth pain, brushing	Y	N
Blisters on lips or mouth	Y	N	Chew on foreign objects	Y	N	Orthodontic treatment	Y	N
Burning sensation on tongue	Y	N	Grinding teeth	Y	N	Pain around ear	Y	N
Chew on one side of mouth	Y	N	Gums swollen or tender	Y	N	Sensitivity to cold	Y	N
Cigarette, pipe, or cigar smoking	Y	N	Jaw pain or tiredness	Y	N	Sensitivity to heat	Y	N
Clicking or popping of jaw	Y	N	Lip or cheek biting	Y	N	Sensitivity to sweets	Y	N
Dry mouth	Y	N	Loose teeth/broken filings	Y	N	Sensitivity when biting	Y	N

How often do you Floss your teeth? _____

How often do you Brush your teeth? _____

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask. We will be happy to help you.



Medical History



Do you have a personal physician? Y N

Physician's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of Last Visit? _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Y N

If yes, please explain: _____

Have you ever been hospitalized or had a serious illness or operation? Y N

If yes, date and condition treated: _____

For Women: Are you pregnant? Unsure Y or N Week # _____

Are you taking birth control? Y N Are you nursing? Y N

Are you **ALLERGIC** to any of the following?

- Aspirin Codeine Jewelry Erythromycin
- Barbiturates Sulfa Drugs Sedatives Penicillin
- Tetracycline Dental Anesthetics Latex Other

Please list additional drugs that cause allergic reactions: _____

Do you smoke or use tobacco in any other forms? Y N

Are you taking any of the following?

- Acetaminophen Blood Pressure Medication Nitroglycerin Antibiotics Cold Remedies Recreational Drugs
- Antihistamines Digitalis/Heart Medication Steroids/Cortisone Aspirin or Ibuprofen Tranquilizers
- Thyroid Medicine Insulin/Diabetes Drugs Blood Thinners Bisphosphonates Other _____

Are you taking any prescriptions or over the counter drugs? Y N **If yes, please list each one:** _____

Have you experienced the following?

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
Alcohol Abuse	Y	N	Fever Blisters	Y	N	Persistent Cough	Y	N
Anemia	Y	N	Frequent Headaches	Y	N	Psychiatric Problems	Y	N
Arthritis	Y	N	Glaucoma	Y	N	Radiation Treatment	Y	N
Artificial Bones/Joints	Y	N	Hay Fever	Y	N	Rheumatic Fever	Y	N
Artificial Valves	Y	N	Heart Attack	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Heart Surgery	Y	N	Severe Headaches	Y	N
Cancer	Y	N	Hemophilia	Y	N	Shingles	Y	N
Chemotherapy	Y	N	Hepatitis: A / B / C	Y	N	Sickle Cell Disease	Y	N
Chicken Pox	Y	N	Herpes	Y	N	Sinus Problems	Y	N
Colitis	Y	N	High Blood Pressure	Y	N	Steroid Therapy	Y	N
Congenital Heart Defect	Y	N	HIV+/AIDS	Y	N	Stroke	Y	N
Diabetes: Type 1 / Type 2	Y	N	Hospitalized	Y	N	Thyroid Problems	Y	N
Difficulty Breathing	Y	N	Kidney Problems	Y	N	Tonsillitis	Y	N
Drug Abuse	Y	N	Liver Disease	Y	N	Tuberculosis (TB)	Y	N
Emphysema	Y	N	Low Blood Pressure	Y	N	Ulcers	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N

Please List any serious medical condition(s) that you have experienced: _____

*I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify Dr. William L. Farrell DDS, of any change in my health or medication prior to treatment.

Signature of Patient, Parent or Guardian

Date

William L. Farrell DDS

Assistant

I have verbally reviewed the Medical/Dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____



Scheduling & Consent of Disclosure



Scheduling your Next Appointment

We make every effort to schedule appointments for the convenience of our patients. We need your cooperation to ensure that everyone has an opportunity for timely treatment. Please keep the following in mind:

Early morning, late afternoon, appointments and Saturday (By appointment only) are in great demand in our office. We will be happy to schedule you for one of these times if one is available, but we ask that you please make every effort to keep the appointment. Last minute changes often prevent us from offering these popular times to other patients who have requested them.

We fully understand that there are times when illness or unexpected obligations cause patients to reschedule appointments. However, we ask that you honor your appointments whenever possible so that you can stay on schedule and derive the maximum benefit from your treatment.

Notice: We do not double/triple- book at this office and as a courtesy to other patients, we request that you notify us within 24 hours if you need to change your scheduled appointment.

As of June 1, 2015: There will be a fee of \$50.00 assessed if we do not receive a call to cancel an appointment.

ALL Saturday Appointments: There will be a fee of \$100.00 assessed if we do not receive a call to cancel an appointment. Failure to do so could result in termination of services.

Thank you for choosing us for your dental care. If at any time, you have any questions about any of our services, please feel free to call us.

(Signature) _____

(Date) _____

Consent of Disclosure *(For the usage and/or Disclosure of Protected Health Information)*

I hereby give consent to William L. Farrell DDS, and all health care providers furnishing care within the offices of William L. Farrell DDS, to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered by person or by mail, but it will only be effective when we physically receive it. Your cancellation will not be effective to the extent that we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of you protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting the Office Manager.

Patient Name (Please Print) _____

Signature of Patient _____

Date _____ / _____ / _____

If you are signing as the patient's representative:

Relationship _____

Address for cancelation: Your cancellation will be effective, upon receipt, at the following address:

William L. Farrell D.D.S., 9461 Deschutes Road, Suite 2 Palo Cedro, CA 96073