Dental History

Name: _____ Date:_____

How may we help you today? _____

I consider my current dental health to be: ☐ Good ☐ Fair ☐ Poor

I am currently in pain. ☐ Yes ☐ No

I require antibiotics before dental treatment. For: _____ ☐ Yes ☐ No

My teeth are sensitive to Hot/Cold or something else. ☐Yes ☐ No

My last dental hygiene appointment was on or about: _____

My last dental exam was on or about: _____

I floss _____ times a week. I brush: _____ times a day.

I currently have braces or I've had orthodontic treatment in the past. ☐ Yes ☐ No

My gums bleed. ☐Yes ☐No I've had gum treatment in the past. ☐ Yes ☐ No

I am missing one or more of my teeth. ☐ Yes ☐ No

I have or had pain/discomfort in my jaw joint (TMJ). ☐ Yes ☐ No

I grind or clench my teeth. ☐ Yes ☐ No I wear a night guard. ☐ Yes ☐ No

I snore or have been diagnosed with sleep apnea. ☐ Yes ☐ No

I've been unsatisfied with previous dental work. ☐ Yes ☐ No

I've had unfavorable dental experiences in the past. ☐ Yes ☐ No

I have old fillings or previous dental work that is no longer satisfactory to me. ☐ Yes ☐ No

I am concerned about the shape, position or angle of one or more of my teeth. ☐ Yes ☐ No

There are some things about my front teeth that I would like to change. ☐ Yes ☐ No

I am concerned with the color of my teeth. ☐ Yes ☐ No

In social situations, I am sometimes embarrassed by my teeth or smile. ☐ Yes ☐ No

If yes, what is the cause? _____

I am interested in learning more about cosmetic dentistry. ☐ Yes ☐ No

We offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our knowledgeable staff to discuss with you.

In-Office Whitening	Dental Implants	Tooth Desensitizing
Take-Home Whitening	Veneers	Sealants
Botox	Crowns/Bridges	Sport/Night Guard
White/Brown Spot Removal	Partials/Dentures	Other:_____

How did you hear about us? (check all that apply) ☐Friend: _____

☐ Google ☐ Angie's List ☐Yelp! ☐ Social Media ☐ Insurance ☐ Other: _____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Quinn Dental

HIPPA Informed Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

Patient Name:_____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read out Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and or other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION A: The uses and disclosures being authorized.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notices.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care.

☐ YES ☐ NO **There are others I would like to have access to my records and information.**

Please list the person(s) you would like involved in your care on the line below:

_____

☐ YES ☐ NO **I give Quinn Dental consent to speak with and share information including x-rays and medical records with healthcare providers involved in my treatment.**

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information. Base on this professional judgment we may share/discuss information directly relevant to treatment options, costs and payment options with family members or friends who are involved with your care. (Statute 45 CFR 164.510(b))

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION B: Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to this office. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

SECTION C: Individual giving consent

Name: _____ Patient / Guardian / Parent
(Please Circle One)

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

6373 N Jean Nicolet Glendale, WI 53217 ● qualitycare@quinndental.com ● (414)228-9683

QUINN DENTAL
Office and Financial Policy

Optimal oral health care is achieved through an understanding of patients dental health needs, and services required as well as the financial arrangements for those services.

Payment for all services is the patients' responsibility: As a courtesy we will bill your insurance and make every effort to collect from them. However, in many cases insurance carriers cover only part of the charges. It is ultimately your responsibility to be aware of your coverage and benefits.

Payments are due on the day of service when: the deductible has not been met, insurance pays directly to the patient, insurance has reached their yearly max or if the service is not a covered benefit of your plan.

Methods of Payment: We accept Cash, Check, MasterCard, Visa, and Debit Cards. Quinn Dental assesses a $35 fee for a returned check. More expensive treatment plans such as crowns and partials may require a deposit and/or could qualify for 6 month free financing with *Care Credit*.

Quinn Dental is not a T-19/Medicaid provider: I understand that if I carry this type of insurance there are no benefits are available to me when seeing an out of network provider. I accept responsibility for any charges and understand payment is due at time of service.

Pre-authorization/estimate service: We don't like surprises either! Quinn Dental can pre-authorize and estimate care costs. Speak with us if you would like to pursue this information from third party payers before services are rendered.

Accounts: We do not become involved in domestic matters and do not divide account balances between parties. Copies of payment records are readily available upon request when a signed authorization for release is completed and on file in our office.

Late Payment Charges: Help us keep costs low. A service charge of 1% will be assessed to all billed accounts net 30 days from first statement date. Should you have any questions about your statement, please call the office, we will make every effort to answer and resolve problems.

Cancellation and Missed Appointment Policy

Our office strives to be available to patients at times that are convenient for them. To accomplish this we need your assistance. We require adequate notice if appointments need to be rescheduled or canceled. When a patient fails to show up for an appointment it not only causes a financial loss for us, but it also takes appointment time away from other patients. If you need to reschedule or cancel an appointment, we require a 24 hour notice by phone or email. If needed a message can be left on our voicemail.

Appointments canceled/rescheduled with less than 24 hour notice or missed are subject to a $35 fee.

Patient Name: _____ Date: _____

Signature: _____ Patient / Parent / Guardian
(Please Circle One)