PATIENT INFORMATION

Date_____

S.S. #_____

Patient Name_____
Last Name First Name Middle Initial

Address_____

City_____State_____Zip_____

Sex ☐ Male ☐ Female Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Patient Employer/School_____

Occupation_____

Employer/School Address_____

Employer phone number ( )_____

Spouse's Name_____Birthdate_____

S.S.# _____Spouse Employer_____

Who may we thank for referring you?_____

PHONE NUMBERS

Home (____)_____ Work(____)_____ Ext. _____ Cell Phone (___)_____

Spouse's Work(___)_____ Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____Relationship_____

Home Phone (___)_____Work Phone (___)_____ Cell Phone (___)_____

DENTAL INSURANCE

Who is responsible for this account? _____S.S#_____

Birthdate _____Relationship to patient_____

Insurance Co. _____

Group # _____ ID # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ S.S. #_____

Relationship to Patient _____

Insurance Co. _____

Group # _____ ID# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my depenent(s), have insurance coverage with _____ and assign directly
Name of Insurance Company (ies)
to Dr. Carl Cody Friddle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose for obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date **Relationship to Patient**

HIPPA PATIENT ACKNOWLEDGMENT AND CONSENT

I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document. By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and health care operations.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we may obtain.
You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect the action we have or will take in reliance to this consent before we received your revocation, and that not signing this consent or by revoking such consent in the future, we may reserve the right to refuse treatment.

Print Name:_____ **Date**_____

Signature: _____ If a personal representative on behalf of this patient signs this consent, or is appointed by you as the patient to have shared knowledge of treatment, payment activities, and health care options, please fill out the following information.
Personal Representative's Name: _____**Relationship to patient**: _____

PATIENT QUESTIONNAIRE

Approximately how long has it been since your last dental visit? _____

Has a bad experience or fear of pain kept you from visiting a dentist? ☐ Yes ☐ No

If yes, please explain_____

Are your teeth sensitive to ☐ Heat ☐ Cold ☐ Sweets ☐ Pressure

If yes, please explain _____

Do you wear a partial or denture? ☐ Yes ☐ No If so, are satisfied with the fit? ☐ Yes ☐ No

Please explain any problems _____

_____

Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No

Do you have any clicking or popping in your jaw joints? ☐ Yes ☐ No

Do you suffer from frequent headaches? ☐ Yes ☐ No

Are you aware of clenching or have you been told that you grind your teeth? ☐ Yes ☐ No

Do you need or prefer to use nitrous oxide when having dental treatment done? ☐ Yes ☐ No

Please list below any other concerns or issues that you may wish to discuss: _____

_____

CONSENT FORM

- I understand that I am having any or all of the following treatment done: x-rays, examination, dental cleaning, fillings, inlays/onlays, crowns, bridges, extractions, root canals, dentures, periodontal (gum) treatment, bleaching (tooth whitening), local anesthesia, other _____.
- I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions, including redness and swelling of tissues, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) and they can cause pain, thombophlebitis (inflammation of vein) from intravenous and intramuscular injections, injury to and stiffening of the neck and facial muscles. They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle of hazardous device for at least 12 hours or until fully recovered from the effects of any anesthesia, medication, and/or drugs that may have been given to me in the office for my care. I understand that failure to take the medication prescribed to me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to the effective treatment of my condition.
- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the procedures. I give permission to the treating dentist to make any/all necessary changes.
- Alternatives to extractions of teeth have been explained to me (root canal, crowns, and periodontal treatment, etc.) and I authorize the treating dentist to remove teeth as necessary. I understand removal of teeth does not always eliminate all infection and it may be necessary to have further treatment. I understand the risks involved in having extractions, some which may be pain, swelling, spread of infection, dry socket, excessive bleeding, fractured jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
- For crowns, bridges, veneers, inlays/onlays, and bonding, I understand that it is sometimes not possible to exactly match the color of my natural teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize that the final opportunity to make changes in my new crown, bridge, inlay/onlay, (including shape, fit, size and color) will be before cementation. It has been explained to me that in very few cases, cosmetic or other dental procedures may result in the need for future root canal therapy, which cannot always be predicted or anticipated. In such instances my treating dentist may decide to perform the root canal or refer to an endodontist for such treatment; either way I am responsible for the cost of such procedure. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily oral hygiene.
- For dentures (complete or partials), I realize that these appliances are constructed of plastic, metal, and/or porcelain. Problems associated with these appliances have been explained to me including looseness, soreness, changes in my speech, and breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately 3-12 months after their initial placement. The cost for this procedure is not included in the initial denture fee.
- For root canal treatment, I realize that there is no guarantee that the procedure will save my tooth. Complications can occur from this treatment, and occasionally, additional surgical procedures (apicoectomy and/or retrofill) may be necessary, following root canal treatment. I am aware that, should such complications arise, I would be responsible for the cost of these procedures.
- I have been informed about the risks and consequences of periodontal (gum) disease if left untreated, including infection, pain, looseness, and loss of teeth, possible cardiovascular complications, and bad breath (halitosis). Alternative periodontal treatment plants have been presented to me and I understand that there is no guarantee that these treatments will save my teeth.

I understand that dentistry is not an exact science, and therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I acknowledge the receipt of and understand post-operative instructions. (Please sign below)

I have read and signed the Acknowledgement of Privacy Practices on File.

Signature of Patient (or parent/guardian if patient is a minor)_____

I have received a copy of the Dental Materials Fact sheet as required by law. (Please sign below if applicable):

Signature of Patient (or parent/guardian if patient is minor_____

Date: _____