CLOWARD
DENTAL

Name: _____ Preferred Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Sex: M/F Social Security # _____

Marital Status: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work# _____

E-mail Address: _____ Who Referred You? _____

Emergency Contact Person: _____ Phone# _____

Do you have a family member who is a patient here? _____

Person Responsible for this Account:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone# _____

Insurance Company: _____ Group ID# _____ Phone# _____

Name of Insured: _____ Birth Date: _____ Subscriber ID# _____

Insurance Address: _____

Medical History: Please circle if you have a history of the following:

Aids Asthma Back Problems Cancer Diabetes Epilepsy Hepatitis HIV Hypertension
Jaw Pain Kidney Disease Respiratory Disease Rheumatic Fever Thyroid Problems
Tobacco Habit Artificial Joints Heart Conditions

If any of these were circled, please describe _____

_____

Are you currently pregnant? Yes_____No_____

Heart Condition: Please Describe _____

Artificial Joints: Please Describe _____

Please list other conditions not listed: _____

Please list medications you are taking: _____

Please list any allergies you have: _____

HIPPA: Acknowledgment of Receipt of Notice of Privacy Practices

I _____ date _____ have received a copy of Dr. Aaron D. Cloward and Dr. Jake Haslem's Privacy Policies.

Authorization

I certify that I have read and accurately answered the above questions. I understand that incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or exam rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand my dental insurance carrier may pay less than the actual bill. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also agree to a 40% collection fee if my account is sent to collections, and waive the right to have the 40% fee removed. **THERE IS A $25 NO-SHOW FEE FOR APPOINTMENTS NOT CANCELED WITHIN 24 HOURS.**

Signature of Patient or Guardian X_____ Date _____

Please Print Patient or Guardian's Name: _____

CONSENT TO PROCEED

I authorize Dr._____and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____

(Rev. 2/14)