Patient Information Form

Today's Date _____

Patient Name: First _____ MI ____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ **Home Phone** _____ **Mobile Phone** _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

DENTAL HISTORY

Patient Name _____ Nickname _____ DOB _____

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 sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	☐	☐
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, or can you see more of the roots of your teeth?	☐	☐
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 mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) 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 _____

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 _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ 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 or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, 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 (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
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 or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, 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 or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
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 (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
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, vitamins, and/or probiotics 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)** 

Dr Loveleen Brar BDS PLLC

Health Insurance Portability and Accountability Act (HIPAA)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.

We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring dentist and/or family physician and/or a dentist/physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records.We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, workers compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice. I acknowledge that I have received a HIPAA Compliance Assurance Notification from the office of LoveLeen Brar BDS PLLC

Print Name: _____ **Date:**_____

Signature:_____

If a person representative signs this authorization on behalf of the individual, complete the following:

Personal Representative Name:_____ **Date:**_____

Relationship to the Individual: _____ **Date:**_____

MARIGOLD DENTAL
PUGET SOUND

Loveleen Kaur Brar BDS PLLC

Office Policies / Authorization

Financial Policy

Our goal is to provide patients with the highest quality dental care in a friendly, gentle, and modern environment. Before proceeding with any treatment, all fees and financial agreements will be discussed with you and all your questions will be answered. Dental treatment is an important decision. We take the time to ensure that you understand exactly what is being done, as well as any risks. Please take a moment to familiarize yourself with our financial policy.

Insurance/Patient Responsibility. While we are contracted with most PPO plans, it is ultimately the patients' responsibility for all fees or dental care rendered by our office. Insurance coverage is estimated; your actual indemnity may be more or less. You, the patient, are responsible for all amounts not covered by your insurance carrier. For this reason, we recommend contacting your insurance company if you have any questions. *Payment is expected at the time of service.*

Cancellation/Missed Appointments. In the event that you are unable to make your scheduled appointment, a 48-hour notice is required so we can offer your appointment time to other patients in need of care. A $75 charge will be billed to your account for cancellations without 48 hours notice or for missed appointments.

I have read and understood the financial policy of Marigold Dental / Loveleen Kaur Brar BDS PLLC, and authorize Marigold Dental to bill my insurance and to release all information necessary to secure payment.

Patient Signature _____ Date_____

E-Communications

To improve your experience with us, we offer you the opportunity to receive phone call, text, and email messages related to your care and treatment at Marigold Dental including, but not limited to, appointment confirmations, payment reminders, billing information, and other important information. I understand that texting and email are not 100% secure and that there is some level of risk that third parties might be able to read unencrypted emails or messages. Signing this form is optional and will not impact my ability to receive dental care at Marigold Dental and I can withdraw my consent at any time by calling the office at 253-925-2171.

| acknowledge that I have read and fully understand this consent for e-communications, and I consent to email and text message communications from Marigold Dental.

Patient Signature _____ Date_____