all smiles.

Larry Folden, D.D.S. & Bradley Westbrook, D.D.S.

2110 East Rusk Street
Jacksonville, TX 75766
Phone 903.586.0741
Fax 903.586.0649
www.allsmilesjacksonville.com

DENTAL HISTORY

Patient name | Referred by

Previous dentist | For how long?

Most recent dental exam | Most recent dental x-ray

Most recent dental treatment

How often do you have your teeth cleaned? 3 months 4 months 6 months 1 year or longer

YOUR IMMEDIATE DENTAL CONCERN(S)?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Question		
Unhappy with the appearance of your teeth?	YES	NO
Unfavorable dental experiences?	YES	NO
Dental fears?	YES	NO
Problems with effectiveness or bad reactions to dental anesthetic?	YES	NO
Orthodontic treatment (braces)?	YES	NO
Periodontal (gum) treatment?	YES	NO
Bleeding gums?	YES	NO
Avoid brushing any part of your mouth?	YES	NO
Part of your mouth sensitive to temperature?	YES	NO
Sore teeth?	YES	NO
Burning sensation in your mouth?	YES	NO
Difficulty swallowing?	YES	NO
Unpleasant taste or odor in your mouth?	YES	NO
Dry mouth, throat, and or eyes?	YES	NO
Jaw problems (temporomandibular joint)?	YES	NO
Difficulty opening your mouth widely?	YES	NO
Stiff neck muscles?	YES	NO
Awaken with an awareness of your teeth or jaws?	YES	NO
Tension headaches?	YES	NO
Clench or grind your teeth?	YES	NO
Jaw clicking or popping?	YES	NO
Lost any teeth?	YES	NO
Sweat or tremble alot during examination?	YES	NO
Strange people or places make you afraid?	YES	NO

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

Has your present denture been relined? YES NO

If yes, when (month/year)

Is your present denture a problem? YES NO

If yes, describe

Satisfied with the appearance? YES NO

Satisfied with the comfort? YES NO

Satisfied with the chewing ability? YES NO

When did you receive your first partial or complete denture?

How long have you worn your present denture?

SIGNATURE ______________________ DATE ______________

NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.

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MEDICAL HISTORY

Patient Name Nickname Age

Name of medical physician

Most recent physical examination Purpose

What is your estimate of your general health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING?

Hospitalization for illness or injury	YES	NO
Allergic reaction to		
Aspirin, ibuprofen, acetaminophen		
Penicillin		
Erythromycin		
Tetracycline		
Codeine		
Local anesthetic		
Fluoride		
Metals (gold, stainless steel)		
Latex		
Any other medications		
Heart problems	YES	NO
Heart murmur	YES	NO
Rheumatic fever	YES	NO
Scarlet fever	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
A stroke	YES	NO
Artificial prosthesis (i.e., heart valve or joints)	YES	NO
Anemia or other blood disorder	YES	NO
Prolonged bleeding due to a slight cut	YES	NO
Emphysema	YES	NO
Tuberculosis	YES	NO
Asthma	YES	NO
Sinus problems	YES	NO
Kidney disease	YES	NO
Liver disease	YES	NO
Jaundice	YES	NO
Thyroid or parathyroid disease	YES	NO
Hormone deficiency	YES	NO
High cholesterol	YES	NO
Diabetes	YES	NO
Stomach or duodenal ulcer	YES	NO
Digestive disorders	YES	NO
Arthritis	YES	NO
Glaucoma	YES	NO
Contact lenses	YES	NO
Head or neck injuries	YES	NO
Epilepsy or convulsions (seizures)	YES	NO
Viral infections and cold sores	YES	NO
Any lumps or swelling in the mouth	YES	NO
Hives, skin rash, hay fever	YES	NO
Venereal disease	YES	NO
Hepatitis - Type A B C D E	YES	NO
HIV / AIDS	YES	NO
Tumor, abnormal growth	YES	NO
Radiation therapy	YES	NO
Chemotherapy	YES	NO
Emotional problems	YES	NO
Psychiatric treatment	YES	NO
Antidepressant medication	YES	NO

ARE YOU:

Presently being treated for any illness	YES	NO
Aware of a change in your general health	YES	NO
Often exhausted or fatigued	YES	NO
Subject to frequent headaches	YES	NO
A heavy smoker (one pack or more per day)	YES	NO
Considered a touchy person	YES	NO
Often unhappy or depressed	YES	NO
Easily upset or irritated	YES	NO
Female - taking birth control pills	YES	NO
Female - pregnant	YES	NO
Male - prostate disorders	YES	NO

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List any medications, herbal supplements and/or vitamins taken within the last two years:

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 REMARKS ____________________

____

DOCTOR'S SIGNATURE ____________________

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CONFIDENTIAL QUESTIONNAIRE

PATIENT'S NAME: LAST FIRST MIDDLE

DATE OF BIRTH GENDER: M F SOCIAL SECURITY #

PATIENT'S ADDRESS: STREET APT# CITY STATE ZIP

EMAIL HOME PHONE CELL PHONE

MARITAL STATUS: MARRIED SINGLE UNDER AGE 18

PATIENT'S/GUARDIAN'S EMPLOYER OCCUPATION

WORK ADDRESS: STREET CITY STATE ZIP

WORK PHONE OK TO CALL WORK? YES NO

SPOUSE'S NAME: LAST FIRST MIDDLE

SPOUSE'S EMPLOYER OCCUPATION WORK PHONE OK TO CALL WORK? YES NO

WORK ADDRESS: STREET CITY STATE ZIP

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME RELATIONSHIP HOME # WORK # CELL #

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

SECONDARY INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to Larry L. Folden, DDS. I am financially responsible for any balances due and authorize Larry L. Folden, DDS to release any information for this claim. I authorize that my records can be used by Larry L. Folden, DDS if he so determines.

In consideration of the services rendered to me by Larry L. Folden, DDS, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by Larry L. Folden, DDS in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE ______________________________ **DATE** ______________

NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.

HIPAA CONSENT FORM

Larry L. Folden, D.D.S.   Bradley K. Westbrook, D.D.S.

My signature confirms that I have been informed and understand my rights to privacy regarding protected information, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**. I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to provide, conduct and direct my treatment among the appropriate health care providers who may be involved in that treatment directly and indirectly as well as obtain payment from third party payers.

I have read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or other health care operations. I understand that All Smiles has the right to change the Notice of Privacy Practices and I have the right to contact this office to obtain a copy.

I have read and understand that in signing this HIPAA form, I acknowledge and authorize, that All Smiles provided this HIPAA Notice of Privacy Practices for my knowledge and my consent.

Patient's name:______________________________Date of Birth: ____________________

Relationship to patient (if parent or guardian):___________________________________

Patient or Guardian's signature: ________________________________Date:__________

Authorization for Release of Information to Family Members

I authorize All Smiles Jacksonville to release my medical and/or billing information to the following individual(s):

1.___________________________________**Relation to Patient:**________________

2.___________________________________**Relation to Patient:**________________

3.___________________________________**Relation to Patient:**________________

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.
You have the right to revoke this consent in writing.

Signature:______________________________ **Date:**______________________________