



BARNETT-DAVIS DENTAL GROUP

1427 West State Hwy J Ozark, MO 65721
(417) 581-3600
www.BarnettDavisDental.com

Name _____ SS# _____
Last First Middle

Preferred Name _____ Date of Birth _____ Male Female Marital Status _____

Address _____

City/State/Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____ May we call you at work? _____

Employer _____ Occupation _____

May we call you at your work number? _____

Who may we thank for referring you to our office? _____

How did you hear of our office? Yellow Pages Website Newspaper Magazine Outside Sign Physician Other _____

Spouse/Responsible Party information

Name _____ SS# _____

Address _____ City/State/Zip _____

Phone _____ Email _____ Date of Birth _____

Employer _____ Occupation _____

Method of payment or co-payment: Cash Check Visa MasterCard Discover Care Credit or other finance company

Insured's Name _____ Insured's Employer _____ Date of Birth _____

Dental Insurance Company _____ Address _____

Group _____ Policy # _____ ID# _____

DENTAL HISTORY

Reason for visit: _____

Last dental visit: _____ Purpose: _____

Last complete exam: _____ Name and location of previous Dentist: _____

- | | | | |
|---------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Do your gums bleed while brushing or flossing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Does food tend to become caught between your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to hot or cold? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bite your lips or cheeks frequently? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to sweet or sour things? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had difficult extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel pain in any of your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Has fear of discomfort kept you from regular visits? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have sores/lumps in or near your mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever used Nitrous Oxide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any head, neck or jaw injuries? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Would you like to use Nitrous Oxide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had these jaw problems: | | Have you used whitening products? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had orthodontic treatment (braces)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain (joint, ear, side of face)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had gum treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in opening or closing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you wear dentures or partials? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in chewing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, date of placement: _____ | |
| Do you clench or grind your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you sometimes have dry mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How many sodas/juices/sports drinks do you drink daily? _____ | |
| Are you troubled with bad breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What texture toothbrush do you use? <input type="checkbox"/> Hard <input type="checkbox"/> Med <input type="checkbox"/> Soft | |
| Have you noticed any loosening of your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ | |



MEDICAL HISTORY

Name _____

Physician _____ Office Phone/Location _____ Date of last exam _____

Are you currently under medical treatment? Yes No

Have you ever been hospitalized for any surgical operation or serious illness with the last 5 years? Yes No

Are you taking any blood thinning medication? (Coumadin, Warfarin, etc.) Yes No

Have you EVER taken bone regenerating medications? (Bisphosphonates such as Boniva, Fosomax, Bonefos, Aredia, Zometa, etc.) Yes No

Are you taking any medications causing dry mouth such as antihistamines, sleeping pills or anti-anxiety medications? Yes No

List all other medicine, over the counter drugs, vitamins and supplements that you are currently taking:

Are you allergic to or have reactions to the following?

Local Anesthetic Yes No

Codeine Yes No

Penicillin Yes No

Other Antibiotics Yes No

Aspirin/Ibuprofen Yes No

Any metals (e.g. nickel) Yes No

Latex Yes No

Other allergies Yes No

WOMEN ONLY

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Do you have or previously had any of the following?

Heart Disease or Rheumatic Fever Yes No

High Blood Pressure Yes No

Low Blood Pressure Yes No

Blood Disease Yes No

Heart Trouble, Heart Attack or Angina Yes No

Pacemaker Yes No

Artificial Heart Valve or other Artificial Joint Yes No

Diabetes Yes No

Stroke Yes No

Epilepsy/Seizures Yes No

Cancer or Tumor History Yes No

Radiation Treatment of Head or Neck Yes No

Nervous Disorders Yes No

Kidney Disease Yes No

Hepatitis Yes No

Asthma Yes No

Emphysema or Tuberculosis Yes No

AIDS or HIV positive Yes No

Fainting or Dizzy spells Yes No

Cold sores or Herpes Virus Yes No

Drug/Alcohol Abuse Yes No

Snoring/Apnea Yes No

Arthritis Yes No

Sinus Trouble Yes No

Thyroid Problems Yes No

Any other medical problems Yes No

I certify that I have completed this form fully and completely. The above information is accurate to the best of my knowledge and I understand that providing false information can be dangerous to my health. I grant authority to the Dentist and staff to perform the necessary exam, x-rays, and subsequent treatment needed to restore and maintain my dental health or the health of my dependent.

I authorize and request my insurance company to pay benefits on my behalf directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including any collection costs.

Signature _____ Date _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

Address _____

Telephone _____ E-mail: _____

Social Security# _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

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

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Marcus Barnett, Dr. Kelly Barnett or Dr. Tracy Davis

Telephone: (417) 581-3600 Fax (417) 581-8899

Address: 1427 W. State Highway J, Ozark, MO 65721

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____



SMILE Evaluation

Do you like the way your teeth look? YES NO

Explain: _____

Are you happy with the color of your teeth?
Explain: _____

Do you like the shape of your teeth?
Explain: _____

Would you like for your teeth to be straighter?
Explain: _____

Do you have crowding or spaces between your teeth
that you would like closed?
Explain: _____

Would you like your teeth to be longer?
If so, Upper _____ Lower _____ Both _____

Do you have missing teeth that you would like to replace?
Explain: _____

Do you have old silver fillings that you would
like to replace with tooth-colored fillings?
Explain: _____

If you could change anything about your smile, what would you change?
