EMILY LETRAN, D.D.S., A PROFESSIONAL CORPORATION

We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? _____

Date_____

PATIENT INFORMATION

Patient Name_____ Sex: M □ / F □ Weight_____
Last First Middle
Address_____
Street City State Zip
Home phone (_____)_____ Social Security: _____-_____-_____
Work phone (_____)_____ Driver License # _____
Cell phone (_____)_____ E-mail address _____
Birthdate_____/_____/_____ Marital status: Married □/ Divorced □ / Single □
Employer_____Occupation_____Number years employed_____
Employer address _____
If patient is a minor, give parents/ guardian's name_____
Parent's SS # _____ Parent's cell phone_____Parent's e-mail _____
If patient is a full time student, fill in school name_____
Emergency Contact_____Phone # (_____) _____

Spouse's name_____ _____ _____Relation to patient_____
Last First Middle
Employer _____Occupation_____No. years employed_____
Employer address_____
Social Security #_____Birthdate_____Work phone_____

INSURANCE INFORMATION

Insured's name _____Insured's Soc. Sec. #_____
Insured's Date of Birth: _____Relationship to patient: self / spouse / parent / guardian / other
Insurance Company_____Group Number_____
Ins. Company Address_____Phone#_____

Secondary insurance information (if applicable)
Insured's name_____Insured's Soc. Sec.#_____
Insurance Company_____Group # _____
Ins. Company address_____Phone #_____
Insured's employer_____Phone #_____

DENTAL INFORMATION

Name of previous dentist:_____Phone#_____Address:_____
Reason for leaving_____
Do your gums bleed when you brush? YES □ NO □
Are your teeth sensitive to heat or cold? YES □ NO □ Pressure? YES □ NO □ Sweets? YES □ NO □
Do you grind or clench your teeth? YES □ NO □
Do you have any fear of dental work? YES □ NO □
Date of last dental examination_____
What was done at that time?_____
How would you describe your current dental problem?
_____
How do you feel about the appearance of your teeth?_____
If you can change one thing about your smile, what would it be? _____

MEDICAL INFORMATION

	YES	NO
1. Are you having pain or discomfort at this time?	☐	☐
2. Have you been a patient in the hospital during the past 2 years?	☐	☐
3. Have you been under the care of a medical doctor during the past 2 years?	☐	☐
4. Have you taken any medication during the past 2 years?	☐	☐
5. Are you now taking any medication? If yes, please list:	☐	☐

Physician's name:_____ Phone:_____

Address:_____

_____

6. Are you sensitive or allergic to any medication or anesthetic? If yes, please list:

_____

7. Indicate which of the following you have had or have at the present. **CHECK EACH ANSWER YES OR NO (DO NOT DRAW A LINE THROUGH THE ANSWERS).**

	YES	NO		YES	NO		YES	NO
Heart failure	☐	☐	Diabetes	☐	☐	Sinus trouble	☐	☐
Heart disease/attack	☐	☐	Asthma	☐	☐	Radiation therapy (cancer)	☐	☐
Angina pectoris	☐	☐	HIV Positive	☐	☐	Chemotherapy	☐	☐
Congenital heart disease	☐	☐	Arthritis	☐	☐	Pain in jaw joints	☐	☐
Heart murmur	☐	☐	Epilepsy/seizures	☐	☐	Bleeding problem (dental)	☐	☐
High blood pressure	☐	☐	Rheumatism	☐	☐	Venereal disease	☐	☐
Arteriosclerosis	☐	☐	Cortisone	☐	☐	Cold sores/blisters	☐	☐
Mitral valve prolapse	☐	☐	Drug addiction	☐	☐	Blood transfusion	☐	☐
Artificial heart valve	☐	☐	Kidney trouble	☐	☐	Hemophilia	☐	☐
Heart pacemaker	☐	☐	Ulcer	☐	☐	Anemia	☐	☐
Heart surgery	☐	☐	Thyroid problem	☐	☐	Sickle cell disease	☐	☐
Rheumatic fever	☐	☐	Glaucoma	☐	☐	Bruise easily	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Liver disease	☐	☐
Artificial joints/plate/pin	☐	☐	Emphysema	☐	☐	Yellow jaundice	☐	☐
Tuberculosis	☐	☐	Chronic cough	☐	☐	Fainting/Dizzy spells	☐	☐
Hepatitis A (Infectious)	☐	☐	Hay fever	☐	☐	Nervousness	☐	☐
Hepatitis B (Serum)	☐	☐	Allergy to Latex	☐	☐	History of Phen-Fen	☐	☐
AIDS	☐	☐	Allergies/Hives	☐	☐	Developmentally disabled	☐	☐

8. Do you have, or have you had any condition, disease, or problem not listed? If YES, please list:	☐	☐

_____

9. Have you lost or gain more than 10 pounds in the past year?	☐	☐
10. Do you ever wake up from sleep and feel short of breath?	☐	☐

11. Do you smoke? YES ☐ NO ☐ How many cigarettes per day?_____

FOR WOMEN ONLY: Are you pregnant? YES ☐ NO ☐ If yes, what month?_____

Are you nursing? YES ☐ NO ☐ Are you taking birth control pills? YES ☐ NO ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Today's Date:_____ Signature:_____ Reviewed by:_____ Date:_____

Authorization must be signed by the patient, or by the legal guardian in the case of a minor or when the patient is physically or mentally incompetent.

MEDICAL HISTORY UPDATE

Date:___________________________

Since your last visit to our office, have you:	YES	NO
Seen your physician	☐	☐
Been admitted to the hospital or visited the emergency room	☐	☐

If yes, please indicate the reason ____

Had any changes in the way you are feeling	☐	☐
Started new medications	☐	☐
Stopped previously prescribed medications	☐	☐
Had dental treatment provided in another setting/office	☐	☐
Developed any new dental problem	☐	☐

If yes, please describe:

____

Signature:_______________________Reviewed by:___________________Date:___________

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Date:

Since your last visit to our office, have you:	YES	NO
Seen your physician	☐	☐
Been admitted to the hospital or visited the emergency room	☐	☐

If yes, please indicate the reason_____________________________________

Had any changes in the way you are feeling	☐	☐
Started new medications	☐	☐
Stopped previously prescribed medications	☐	☐
Had dental treatment provided in another setting/office	☐	☐
Developed any new dental problem	☐	☐

If yes, please describe____

Signature:_______________________Reviewed by:___________________Date:___________

- -

Date:

Since your last visit to our office, have you:	YES	NO
Seen your physician	☐	☐
Been admitted to the hospital or visited the emergency room	☐	☐

If yes, please indicate the reason_____________________________________

Had any changes in the way you are feeling	☐	☐
Started new medications	☐	☐
Stopped previously prescribed medications	☐	☐
Had dental treatment provided in another setting/office	☐	☐
Developed any new dental problem	☐	☐

If yes, please describe ____

Signature:_______________________Reviewed by:___________________Date:___________

MUSCULOSKELETAL/OCCLUSAL SIGNS EXAM FORM

Name_____

Date_____Age_____

Symptoms (check all that apply)

☐ Headaches

☐ TMJ pain

☐ TMJ noise

☐ Limited opening

☐ Loose teeth

☐ Vertigo (dizziness)

☐ Facial pain (nonspecific)

☐ Cervical (neck) pain

☐ Difficulty chewing

☐ Postural problem

☐ Trigeminal neuralgia

☐ Bell's Palsy

☐ Nervousness/insomnia

☐ Dysphagia (difficulty swallowing)

☐ Ear congestion

☐ Clenching/bruxing/grinding

☐ Tinnitus (ringing in the ear)

☐ Tender, sensitive teeth (percussion)

☐ Hot/Cold sensitivity

☐ Paresthesia (tingling) of fingertips

Signs

☐ Crowded lower front teeth

☐ Unexplained gum inflammation

☐ Anterior open bite (front teeth not touching)

☐ Facial asymmetry

☐ Forward head posture

☐ Speech abnormalities

☐ Tooth mobility

☐ Flared out upper front teeth

☐ Open contacts (spaces between teeth)

☐ Wearing of lower front teeth

☐ Cervical erosion (wearing of teeth at gum line)

☐ Chipped front teeth

☐ Fractured teeth

☐ Loss of molar teeth

GENERAL DENTISTRY INFORMED CONSENT

1. Drugs and Medications
I understand that antibiotics, analgesics, and other medications can cause allergic and other reactions causing redness and swelling of tissues, pain, itching, and/or anaphylactic shock.
Initials/Date_____/_____

2. **Changes in treatment plan**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination; for example, root canal therapy following routine restorative procedures or crowns. Therefore, fees can only be estimates and are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I give permission to the Dentist to make any/all changes and additions as necessary.
Initials/Date_____/_____

3. Removal of teeth
Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____and any others necessary for reasons in paragraph #2. 1 understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, bone fracture, dry sockets, 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 treatment by a specialist if complications arise during treatment, the cost of which is my responsibility.
Initials/Date_____/_____

4. Crowns, Bridges, and Caps
Conditions that require crowns to be made may also require root canals for their resolution which sometimes become apparent only after the crowns have been placed. I understand that I may be wearing temporary crown that may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are permanently cemented. It is also my responsibility to return for permanent cementation within I 0 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there may be additional charges for remakes due to my delaying permanent cementation. I understand that sometimes it is not possible to match the color of my natural teeth exactly with artificial teeth. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before permanent cementation.
Initials/Date_____/_____

5. Endodontic treatment (Root canal)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment, and that occasionally root canal filling material may extend from the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic file and reamers are very fine instruments, and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it.
Initials/Date_____/_____

6. Periodontal loss (Tissue and bone)
I understand that I have a serious condition, causing gum and bone inflammation or loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition by complicating oral hygiene procedures.
Initials/Date_____/_____

7. Fillings
I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that significant sensitivity is a common after-effect of a newly placed filling.
Initials/Date_____/_____

8. Dentures
I understand that wearing dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures may require considerable adjustings and several relines. A permanent reline will be later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures and that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.
Initials/Date_____/_____

I hereby authorize any of the doctors or dental auxiliaries to proceed with x-rays and exam. I understand the treatment and fees will be explained to me before the procedures. **I understand that, regardless of any dental insurance coverage I have, I am responsible for payment of dental fees. I agree to pay any attorney fee, collection fee, or court costs that may incur to satisfy this obligation.**

SIGNATURE OF PATIENT_____ DATE_____

SIGNATURE OF DOCTOR_____ DATE_____

EMILY LETRAN, D.D.S., M.S., A.P.C.

FINANCIAL POLICY CONCERNING INSURANCE

1. **Patients who carry Dental Insurance (Indemnity, PPO, HMO, etc.) should remember that professional services are rendered by Dr. Letran and /or Associates to the patient and NOT to the Insurance company.**

2. Insured families, therefore, are expected to be responsible for payment for all services, **whether or not they are paid by their insurance company.**

3. Even though an insurance claim is filed by this office, you will receive regular monthly statement while we are waiting for the insurance company to pay the bill. This office cannot accept responsibility for collection of insurance claims not promptly paid by your insurance company or for negotiating a settlement on a disputed claim.

4. Even if you assign your insurance benefits to us, we will expect regular payments from you on all amounts owing beyond thirty days after we submit a bill to your insurance company. In the event that your insurance company rejects your claim or the amount that the insurance company pays is less than the amount due according to contract, we will ask you to pay the amount that the insurance company has not paid. This amount is due **within thirty days** of our request to you.

5. Claims to your insurance company are due and payable within thirty (30) days of our billing the insurance company. **If your insurance company fails to pay us within thirty days, you will be expected to pay the amount due within the next thirty days, unless other prior arrangements have been made by you with us.** You should be aware that many insurance companies may pay claims very slowly. This does not eliminate your responsibility to pay promptly. Accounts unpaid after sixty (60) days may be referred to a collection agency.

6. Many conditions or treatments are **not covered** by most insurance policies. Patients with these treatments must pay for services rendered at the time of their visit. We will then be happy to assist you by billing your insurance for you in the event that the company might reimburse you.

I have read and understood the foregoing statements. **Regardless of my insurance status, I am ultimately responsible for the payment of my account.** I will notify this office immediately if any of the information, including my insurance status, changes.

Patient's signature:_____

Date:_____