

The Dental **SPECIALISTS**

PATIENT BILL OF RIGHTS

- You have the right to be treated with respect, consideration, and dignity by doctors and team members in this dental practice.
- You have the right to privacy as it relates to your patient information and dental care. Patients shall be assured confidential handling of their dental and financial records and may approve or refuse their release, except when required by law.
- You have the right, to the degree known, to receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- You have the right to refuse participation in scientific research.
- You have the right to change dentists within the practice or transfer to another The Dental Specialists location.
- You have the right to be informed of the wide range of dental services available to you.
- You have the right to after-hours and emergency care should the need arise.
- You have the right to be informed of the payment/financial policy.
- You have the right to express grievances or make suggestions by submitting them in writing to:

The Dental Specialists
2200 County Road C West, Suite 2210
Roseville, MN 55113

PATIENT RIGHTS AND RESPONSIBILITIES

The Dental Specialists endorses the Patient Bill of Rights, which is printed on the reverse side of this sheet.

Patients have the responsibility to:

- Be considerate of the privacy and rights of other patients and be respectful of the doctors and team members.
- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider for you and/or your children, and participate in his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Notify The Dental Specialists at least 24 hours in advance if unable to keep scheduled appointment(s).
- Understand and ask questions regarding treatment.
- Continue care with recommended appointments and follow through with after care instructions.

If you have questions, please call your dental practice.

Thank you for choosing The Dental Specialists.

Patient Personal Information

Title _____ Nickname _____ Birth Date _____ Age _____
 Last, First _____ Marital Status _____ Gender _____
 Address _____ Home # _____ Work # _____
 _____ Cell # _____ Drive Lic _____
 City, State, Zip _____ Student _____ SSN _____
 Email _____ School Name _____
 _____ How did you hear about our practice? _____
 Is patient responsible for paying bills? Yes No

Person responsible/guarantor for paying bills

Title _____ Nickname _____ Birth Date _____ Age _____
 Last, First _____ Marital Status _____ Gender _____
 Address _____ Home # _____ Work # _____
 _____ Cell # _____ Drive Lic _____
 City, State, Zip _____ SSN _____
 Email _____

Dental Insurance

Do you have **Primary** Dental Insurance? Yes No
 Group No./Name _____
 Insurance Name _____
 Phone # _____
 Employer Name _____
 Subscriber Last, First _____
 Subscriber Address _____
 City, State, Zip _____
 Relationship to Patient _____
 Birth Date _____
 Subscriber ID _____

Do you have **Secondary** Dental Insurance? Yes No
 Group No./Name _____
 Insurance Name _____
 Phone # _____
 Employer Name _____
 Subscriber Last, First _____
 Subscriber Address _____
 City, State, Zip _____
 Relationship to Patient _____
 Birth Date _____
 Subscriber ID _____

Name: _____ DOB: _____

Medical Alerts

Do You Have the Following:

- Amoxicillin Allergy
- Aspirin or Ibuprofen Allergy
- Augmentin Allergy
- Epinephrine Sensitivity Allergy
- Erythromycin Allergy
- Clindamycin Allergy
- Codeine / Other Pain Killers Allergy
- Iodine Allergy
- Latex or Rubber Product Allergy
- Local Anesthetics Allergy
- Metals Allergy
- Penicillin Allergy
- Sedatives or Barbiturates Allergy
- Sulfa Drugs Allergy
- Other Allergy (list on Medical Questionnaire)

Are You Using the Following

- Antibiotics
- Anticoagulants/Blood Thinners
- Aspirin
- Cortisone/Prednisone
- High Blood Pressure Medication
- Insulin
- Motrin/Aleve/ Ibuprofen
- Oral Anti-Diabetic
- Nitroglycerin

Currently Taking or Ever Taken

- Actonel
- Aredia
- Boniva
- Fosamax
- Prolia
- Reclast
- Zometa
- Other Bisphosphonates

Check, if applicable

- Premedication Needed
- Alcohol/Drug Abuse
- Cancer/Tumor Growth

- Chemotherapy/Radiation
- Communication Issue
- Development Delay
- Learning Problems
- Organ Transplant
- Sensory Integration Disorder
- Wheel Chair

EYE, EAR, NOSE, THROAT PROBLEMS

- Canker Sores
- Cold Sores (Herpes)
- Ear Aches (Otitis)
- Frequently Dry Mouth/Sjogren
- Glaucoma
- Large Tonsils or Adenoids
- Hay Fever/Seasonal Allergies
- Hearing Impaired
- Sinus Trouble
- Vision Loss

HEART PROBLEMS

- Mitral Valve Prolapse
- Angina
- Chest Pain
- Congenital Heart Defects
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- Heart Surgery
- Heart Damage
- Heart Murmur
- Heart Valve Replacement
- Irregular Heart Beat

PACEMAKER

- Defibrillator
- Rheumatic Fever

LUNG PROBLEMS

- Asthma
- Bronchitis
- Chronic Cough
- COPD

- Emphysema
- Pneumonia
- Reactive Airway Disease
- Shortness of Breath
- Sleep Apnea
- Tuberculosis

VASCULAR/BLOOD PROBLEMS

- Anemia
- Leukemia
- Excessive, Prolonged Bleeding
- High Blood Pressure
- Low Blood Pressure
- Leg Bypass Surgery

GASTROINTESTINAL PROBLEMS

- Acid Reflux
- Cirrhosis
- Colitis
- Crohn's Disease
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hiatal Hernia
- Intestinal Bleeding
- Ulcers

GENITOURINARY PROBLEMS

- Dialysis
- Kidney Disease/Failure
- Urinary Tract Infections

MUSCLE/BONE/SKIN PROBLEMS

- Arthritis
- Artificial Joints
- Back Problems
- History of Skin Problems
- Joint Problems
- Muscle Problems
- Neck Problems
- Osteoporosis

NERVOUS SYSTEM PROBLEMS

- ADD/ADHD

- Alzheimer's Disease
- Anorexia / Bulimia
- Anxiety
- Autism Spectrum Disorder
- Bipolar Disease
- Cerebral Palsy
- Dementia

- Depression
- Epilepsy
- Fainting Spells
- Injury to Head
- Migraines
- Muscular Dystrophy

NUMB AREAS

- Paralysis
- Parkinsons Disease
- Seizures
- Stroke

OTHER PSYCHIATRIC CONDITION

ENDOCRINE PROBLEMS

- Diabetes Type 1
- Diabetes Type 2
- Low Blood Sugar
- Thyroid Problems

IMMUNE SYSTEM PROBLEMS

- AIDS/HIV
- Lupus
- Rheumatoid Arthritis

OTHER PROBLEMS

- Jaundice
- Liver Disease
- Measles, Mumps, Chickenpox
- Other Medical Condition

Name: _____ DOB: _____

Dental Questionnaire

1. Name, Address & Phone of Previous/Referring dentist: _____
2. When did you last visit a dentist? _____
3. What was done at that time? _____
4. Why did you leave that dentist? _____
5. Date of your last cleaning _____
6. Date of your last exam _____
7. Date of your last full series of x-rays _____
8. Date of last cavity detection (bitewing) x-rays _____
9. Has any dental treatment been recommended to you that you have not done? Yes; Describe: _____ No
10. Are you aware of any dental problems? Yes; Describe: _____ No
11. What do you feel is the present condition of your mouth? _____
12. Do your gums bleed while brushing or flossing? Yes No
13. Have you ever been treated for gum disease? Yes; what was done: _____ No
14. Are your teeth sensitive to any of the following: Sweet Cold Heat Pressure Nothing
15. Are you happy with the appearance of your smile? Yes No; Explain: _____
16. Are you concerned with bad breath (malodor)? Yes No
17. Are you concerned with snoring or sleep apnea? Yes No
18. Are you concerned with grinding your teeth (bruxism)? Yes No
19. Are you aware of possible TMJ problems (does your jaw make noise or lock up)? Yes No
20. Have you had any injury to your teeth, jaw or face? Yes; Describe: _____ No
21. Do you have dental anxiety? Yes No
22. If yes, is there anything you are aware of that helps alleviate the anxiety? _____

Additional Comments

Is there anything else that would be helpful for your dentist to know? Yes No

Name: _____ DOB: _____

Medical Questionnaire

1. Emergency Contact Name and Phone #: _____
2. Primary Physician Name, Address and Phone: _____
3. Referring Physician Name, Address and Phone: _____
4. Are you in good health? Yes No
5. When was your last physical examination? _____
6. Are you currently under care of a Physician? Yes; Condition: _____ No
7. Have you had any serious illness, operation, accident or been hospitalized? Yes; Describe: _____ No
8. Has there been any change in your general health in the past year? Yes; Describe: _____ No
9. Are you currently taking any medication other than listed earlier, including OTC, vitamins or herbal remedies? Yes; Please provide a list. _____ No
10. Have you had previous problems with general or local anesthesia? Yes; Describe: _____ No
11. Do you have any allergies besides what was listed in the Patient Medical Information Section? Yes; Describe: _____ No

Women Only

12. Are you pregnant or is there a chance you may be pregnant? Yes- Due Date _____ No
13. Are you currently nursing? Yes No

Family/Personal/Social History

14. Mother Healthy? Yes No; Explain: _____
15. Father Healthy? Yes No; Explain: _____
16. Do you now or have you ever used:
 - Tobacco/Chew/e-cigarettes No Yes Frequency _____ Number of years _____ Quit Date _____
 - Alcohol No Yes Frequency _____ Last Drink _____ Quit Date _____
 - Recreational/Street Drugs No Yes Frequency _____ Number of Years _____ Quit Date _____

Additional Comments

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient's Signature (Parent/Guardian) Date

Dentist/Doctor's Signature Date

INFORMATION UPDATED

Patient's Signature (Parent/Guardian) Date

Dentist/Doctor's Signature Date

Patient Medication Form

Patient Name		ID #		DOB		Gender	<input type="checkbox"/> M <input type="checkbox"/> F
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Medication & Dosage	Indication for Use	Start Date

Updated Form – Admin Only	
Date	Name

For Admin Use Only – Entered into QDW		
Date		Name

The Dental **SPECIALISTS**

New Patient Radiograph Request Form

(Send this form to your current/former dentist)

Please send my/our most current Complete Series & Bitewing Radiographs to:

(Please print the practice information for The Dental Specialists location you wish to have your records sent to below.)

Practice: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Please print name(s) for ALL patients whose records
need to be sent:

Please print corresponding date(s) of birth:

Patient/Parent Signature: _____ Date: _____