TDS THE DENTAL SPECIALISTS

Patient Bill of Rights:

At The Dental Specialists, we endorse a patient bill of rights. We strive to provide patients with personalized, comprehensive and patient-centered care. Thank you for trusting us with your oral health and welcome!

At The Dental Specialists, you have the right:

- To be treated with respect, consideration, and dignity by all doctors and team members in the dental practice.
- To privacy as it relates to your personal 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.
- To the degree known, receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- To be given the opportunity to participate in decisions involving your dental care, except when such participation is not possible for medical reasons.
- To request an interpreter if necessary.
- To refuse participation in scientific research.
- To change dentists within the practice or transfer to another location.
- To be informed of the wide range of dental services available to you.
- To after-hours and emergency care should the need arise.
- To be informed of the payment/financial policy.
- To provide feedback, express grievances or make suggestions by verbally communicating them to a doctor or team member, through our patient satisfaction survey or by submitting them in writing to:

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

Patient Rights and Responsibilities:

As a patient, you have the responsibility to:

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

If you have any questions, please speak with your doctor or call your dental practice. We are here for you.

TDS 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: _____

THE DENTAL SPECIALISTS

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
- ☐ Hiatial 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: _____

THE DENTAL SPECIALISTS

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: _____

THE DENTAL SPECIALISTS

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

TDS THE DENTAL SPECIALISTS

Patient Medication Form

Patient Name		ID #		DOB		Gender	__ M __ F

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 ent:	Please print corresponding date(s) of birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient/Parent Signature: _____ Date: _____