Midwest Dental Center LLC

General Dentistry

Welcome!

In order for us to thoroughly diagnose and plan your dental treatment, we must have accurate background & health information. Please provide the information requested below so that we can give you our best consideration during your initial visit to our office.

Date _____

Name _____ Nickname _____ Home Phone _____

Birthdate _____ M/F _____ Age _____ S.S. # _____

Home Address _____ City _____ Zip Code _____

Name of Spouse/ or Parent If Minor _____ Spouse's or Parent's Employer _____ Spouse's or Parent's S.S. # _____

Employer _____ Telephone: Business _____

Business Address _____ Driver's License No. _____

How did you first hear about us? _____

If Patient is a minor, who is financially responsible for this bill? (Last Name, First Name) _____ S.S. # _____ Employer: D.O.B.: _____

Do you have dental insurance? Yes No If so, what company? _____ Group # _____

Preferred Method of Payment ☐ Cash/Check ☐ MC/Visa ☐ American Express ☐ Discover

Whom may we contact in case of emergency? _____ Relationship _____ Telephone # _____

What prompted you to seek dental care at this time? _____

How long since your last thorough dental examination? _____ Name of Dentist _____

Are you satisfied with your past dentistry? If not, why? _____

Name of physician: _____ Telephone # _____

Are you under care of a physician now? For what reason? _____

Are you allergic to: Penicillin ☐ Codeine ☐ Local anesthetics ☐ Other ☐ If other, what? _____ None ☐

Do you have any problems with any medications? _____

What medicine's are you now taking? _____ For what purpose? _____

Women: Are you pregnant? _____ Do you anticipate becoming pregnant? _____ Are you nursing? _____

Have you ever been treated for:

	Yes	No		Yes	No		Yes	No		Yes	No
Mitral valve prolapse	☐	☐	Artificial joint	☐	☐	Chemotherapy / Radiation (Cancer, Leukemia)	☐	☐	Alcohol or drug addiction	☐	☐
Heart disease or attack	☐	☐	Anemia	☐	☐		☐	☐	Emphysema	☐	☐
Angina Pectoris	☐	☐	Stroke	☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐
Congenital heart lesions	☐	☐	Tuberculosis	☐	☐	Rheumatism	☐	☐	Venereal disease	☐	☐
Heart murmur	☐	☐	Asthma	☐	☐	Kidney trouble	☐	☐	Cold sores	☐	☐
Artificial heart valve	☐	☐	Hay fever	☐	☐	Hepatitis	☐	☐	Epilepsy or seizures	☐	☐
Heart pacemaker	☐	☐	Sinus trouble	☐	☐	HIV Virus / AIDS	☐	☐	Fainting or dizzy spells	☐	☐
High blood pressure	☐	☐	Allergies or hives	☐	☐	Jaundice	☐	☐	Sickle cell disease / trait	☐	☐
Rheumatic fever	☐	☐	Diabetes	☐	☐	Blood transfusion	☐	☐	Ulcers	☐	☐
Migraine headaches	☐	☐	Frequent ear pain	☐	☐	Do you smoke?	☐	☐	Liver disease	☐	☐
Scarlet fever	☐	☐	Thyroid disease	☐	☐	Do you chew tobacco?	☐	☐	Clicking or jaw-joint pain	☐	☐

When you walk up stairs or take a walk, do you have to stop because of pain in the chest, shortness of breath, or tiredness? ☐ Yes ☐ No

When and how often do you brush your teeth? _____

Do your gums bleed easily, feel tender or irritated? ☐ Yes ☐ No

Are your teeth ever sensitive? ☐ Yes ☐ No If yes, what are they sensitive to? _____

Are you aware of grinding or clenching your teeth? _____

Is there anything you would like to change about the way your smile looks? _____

To the best of my knowledge, all of the preceding answers are true and correct. If there ever is a change in my health, or if my medicines change, I will inform the dentist before my next appointment without fail.

Signature of patient, parent, or guardian _____ Date _____

TIME

Midwest Dental Center

DATE

MEDICAL HISTORY

FOR

Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Date: _____

Informed Consent for Oral Surgery, Fillings, Crowns, Root Canals and Other Procedures

Last Name:_____**First Name:**_____**Guardian Name:**_____ **Phone of Guardian**_____

Home:_____ **Mobile:**_____ **E-mail Address:**_____

Home Address:_____ _____**City**_____**State:**_____**Zip:**_____

Emergency Contact :_____ **Phone:**_____ **Address**_____

Employer Name:_____**Phone:**_____**Address**_____**City:**_____**State**____**Zip:**___

Dental Insurance:_____**ID/Group**_____**SSN**_____**DOB**_____

Dental insurance Policy Holder Last Name:_____**Fisrt Name**_____**SSN**_____**DOB**_____

"I or my Guardian is responsible for payment of dental services rendered if my insurance did not pay for dental service." (Dental office to contact me for next checkup or procedures phone #_____ and email address_____)

Procedures: (1) Extraction:_____(2) Fillings:____(3) Cleaning:_____(4) Bridge:_____(5) Adjust Dentures or Partials :____
(6) Exams and X-rays:_____(7) Crowns:_____(8) Root Canals :_____(9) Dentures and Partials:_____ (10) Bleaching_____

After I have been diagnosed with the following procedures: Surgery/Crowns/Bridges/Root Canal/Restorations/Others: I understand that if this tooth/teeth are not Removed Filled/Crowned/Performed Root Canal/Other, my condition may worsen resulting in complications including but not limited to: (1)Infection/Swelling, Sensitivity (2) Lose of additional teeth, Pain, Cyst or Tumor, formation Periodontal (gum) Disease (3) Increased risk of complications if removal is required at a later time.(4) The procedure must be completed by Dentist once started. Possible complications, which have been explained to me, include but are not limited to: (1) Dry Socket, Infection, Swelling, Bleeding, Bruising and pain. (2) Injury adjacent to teeth, fillings or bone. Injury to nerves of lower upper lip, tongue and cheeks causing numbness, which may be permanent. Unusual reactions to medication. (3) Deciding to leave a small piece of root in jaw when its removal would require extensive surgery could increase risk of complications and the sinus above the upper teeth becoming open.

All prosthodontics/crowns/root canals started must be completed and picked up. When procedures, prosthodontics/crowns/etc are started I agree to pay the full amount of the procedures even if payment was not made by insurance company or I changed my mind.

I agree to cooperate completely with Dr. Taiwo Ngo & associates, and will follow post operative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to discuss my surgery, root canal, crowns, fillings, bridge dentures/partials. and ask questions concerning the procedures. I consent to treatment. I understand that a perfect result cannot be guaranteed.

Patient/Guardian Last Name_____**First Name**_____**Signature**_____**Date**_____

Dr. Signature:_____**Date**_____

HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to obtain a current copy of this Notice of Privacy Practices. By signing below, I acknowledge that I have a copy of this office Notice of Privacy Practices form.

Patient Name (Guardian)_____**Signature**_____Date_____**Relationship to Patient**_____

Documentation of Failure to obtain signed acknowledgement On_____ _____ presented this acknowledgement of receipt of Notice of Privacy Practices form to _____(the patient). The patient refused to provide a signature when requested.