Drs. Carney & Sorensen, DDS

800 1st Avenue North, Suite 2 Clear Lake, Iowa 50428

We thank you for choosing our office. Please know that it is our goal to make your dental experience a positive one. Please fill out the information below in detail to help us get to know you better. Thank you again for allowing us to serve your dental needs.

Patient Information

Patient Name_____
Last First Middle Initial Preferred Nickname

Mailing Address:_____
Address City State Zip

Email Address :_____

Gender: Male Female **Birth Date**: __/___/___ **Social Security Number**: _____

Marital Status: Single Married Widow Separated Divorced

Home Phone #_____Cell Phone #_____Daytime Phone 8-5_____

Best Way to contact you to verify appointments_____

Employer_____ Work Phone #_____

If student, name of School:_____City_____Grade:_____

Other Contact (relative or friend NOT living at your home)_____Phone _____

Whom may we thank for referring you to our office _____

Dental Insurance

Primary Carrier
Subscriber Name_____ Insurance # or SS#_____

Employer_____ Birthdate_____

Secondary Carrier
Subscriber Name_____ Insurance # or SS #_____

Employer_____ Birthdate_____

Insurance Authorization Statement
I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. Our Dental office is only able to estimate the dental insurance payment. I understand that I am responsible for all costs regardless of my insurance coverage. The information on this page is correct to the best of my knowledge.

Signature_____Date_____

Agreement to Pay

I agree to FINANCIAL RESPONSIBILITY for my/my family's treatment. In the event a quotation of fees is not given to me before the services being performed, I shall ask for such a quotation or waive my right to later claim the fees exceeded the value of services rendered.

In the event that payment for dental services is not made within sixty (60) days of the receipt of statement, then a service fee at the prevailing rate of 18% will be added to the past due balance. If collection services or legal services are required to obtain payment of the amount billed, I further agree to pay for all legal fees and costs reasonable incurred in connection with my therewith. I may request a copy of this form.

Responsible Party Signature_____**Date**_____

IF PATIENT IS UNDER 18

Please be aware of our office policy regarding financial responsibility of children of more than 1 family: The parent bringing in the child and scheduling appointments will be responsible for charges incurred. The parents will be responsible for communicating to each other regarding costs and appointments.

Responsible Party Signature_____Relation to Patient_____

Address_____City_____State_____Zip Code_____

Telephone (____)_____

Consent for Use and Disclosure of Health Information

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 operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Policy 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 disclosures we may make of our 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.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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.

Permission to release information to person listed below not living in same household:

NAME & ADDRESS_____

I have had full opportunity to read and consider the contents of the above Consent form, your Notice of Privacy Practices, and your agreement to pay policy. 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 our treatment and health care operations.

SIGNATURE_____**DATE**_____

Drs. Carney & Sorensen, DDS

Medical History and Information

Your answers are for our records and will be confidential.

Patient Name_____ **Today's Date**_____

Name of Physician _____Primary Pharmacy_____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain if yes:_____

Do you currently, or have you ever had the following medical conditions?

YES NO Heart Disease
YES NO Artificial Heart Valve, Damaged Valves, or Murmur
YES NO Chest Pain/Angina
YES NO Rheumatic Heart Disease
YES NO Congestive Heart Failure
YES NO Heart Attack/Stroke (if yes date:_____)
YES NO Heart Surgery/Pacemaker/Defibrillator
YES NO High Blood Pressure
YES NO History of Endocarditis
YES NO Blood Disorders
YES NO Are you taking blood thinners?
YES NO Blood Transfusion
YES NO Anemia
YES NO Hemophilia/Abnormally Prolonged Bleeding
YES NO Liver Disease
YES NO Jaundice
YES NO Hepatitis (if yes: A, B, C, other)
YES NO Respiratory Disease
YES NO Asthma
YES NO Emphysema
YES NO Tuberculosis
YES NO Sinus Problems
YES NO Have you ever had a major surgery
(if yes, what surgery and date:_____)

YES NO Stomach Ulcer/Frequent Heartburn
YES NO Eating Disorder
YES NO Kidney Problems
YES NO Diabetes
YES NO Thyroid Disease
YES NO Artificial Joints/Implants (if yes date:_____)
YES NO Arthritis or Dexterity problems
YES NO Epilepsy/Seizures/Fainting
YES NO Decreased immunity (drug, disease, transplant)
YES NO Cancer or Leukemia (type_____)
YES NO Chemotherapy/Radiation
YES NO Lupus
YES NO Spleen Removal
YES NO HIV/AIDS
YES NO Hearing Impairment
YES NO Glaucoma
YES NO Infectious Diseases
YES NO Alcohol Abuse
YES NO Substance Abuse
YES NO Drugs for Osteoporosis
YES NO Any other medical conditions?
YES NO Tobacco use
YES NO Behavioral / Mental Conditions

Women: Are you pregnant? ☐ YES ☐ NO Due date: _____

ALLERGIES

Are you allergic to or do you suffer ill effects from any of the following?

☐ Penicillin
☐ Codeine or narcotics
☐ Antibiotics_____
☐ Other allergies_____
☐ Latex/Rubber
☐ Dental Anesthesia
☐ Aspirin or Ibuprofen
☐ Metals (e.g. Nickel, etc.)

MEDICATIONS: Please list any medications, including OTC, "natural", or supplement

_____

_____

_____

_____

_____

_____

Dental Health and Appearance

What is your primary dental concern? _____

Please rate your smile from 1 to 10. (10 being highest)_____

Would you like whiter teeth? _____

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

Why did you leave your last dentist?_____

What did you like most about your last dentist?_____

What did you like least about your last dentist?_____

Approximate date of last dental visit:_____Name & city of previous dentist:_____

Do you feel nervous about having dental treatment?_____

Please answer the following:

Yes No Do you feel pain to any of your teeth?
Yes No Are your teeth sensitive to sweet, hot or cold?
Yes No Are you aware of any broken teeth?
Yes No Do you have any sores or lumps in your mouth?
Yes No Do your gums bleed while brushing or flossing?
Yes No Have you ever been treated for "gum disease"?
Yes No Do your gums feel swollen or tender?
Yes No Do you have bad breath, or a bad taste in your mouth?
Yes No Do you have any loose teeth?
Yes No Do you use tobacco?
Yes No Have you had any difficult extractions in the past?
Yes No Have either of your parents lost their teeth to gum disease or been treated for gum disease?
Yes No Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

Yes No Do you have frequent headaches?
Yes No Do you get sinus pain or pressure?
Yes No Do you have popping or clicking in jaw joints?
Yes No Do you have jaw pain?(joint, ear, side of face)
Yes No Do you clench or grind your teeth?
Yes No Difficulty in opening or closing
Yes No Have you had any head, neck or jaw injuries?
Yes No Difficulty in chewing
Yes No Do you wear dentures or partials?
Yes No Have you had braces?

How do you feel about getting and maintaining a healthy mouth?_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.
For purpose of teaching, research and scientific publication, the dentist may use photographs, radiographs, or other diagnostic materials. The identity of the patients will remain anonymous. The patient may view this material for consent and refuse this request.
Payment for all treatment and services rendered are my responsibility.

Sign Here_____**Date**_____
Patient/Parent/Guardian Signature