Madeline Utterback
D.M.D., F.A.G.D.
General, Cosmetic and Implant Dentistry

PATIENT INFORMATION

Name_____ Date: _____
Last First Middle (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child ☐ Other

Date of Birth_____ Social Security # _____

Address_____Apt_____City_____ State_____Zip_____

Cell Phone ( )_____ Home Phone ( )_____ Work Phone ( )_____

Email Address_____Referred by _____

Employer Name_____ Occupation_____
Full time college students, please indicate name of school

Address_____Apt____City_____ State_____Zip_____

Phone ( )_____

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name_____Relationship with patient_____
Last First Middle (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child ☐ Other

Date of Birth_____ Social Security # _____

Address_____Apt_____City_____ State_____Zip_____

Cell Phone ( )_____ Home Phone ( )_____ Work Phone ( )_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: (if applicable)

Insurance Name_____ ID #_____ Group #_____

Address_____Telephone #_____

Insured's Name_____Insured's SS #_____ Insured's Birthdate_____

Insured's Employer_____ Telephone # _____

Secondary Dental Insurance: (if applicable)

Insurance Name_____ ID #_____ Group #_____

Address_____Telephone #_____

Insured's Name_____Insured's SS #_____ Insured's Birthdate_____

Insured's Employer_____ Telephone # _____

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Thank you for choosing our office for your dental care needs. Our primary mission is to deliver high quality oral care with compassion, careful attention and deep personal respect.

We promise:

- To focus on you. We schedule only one appointment at a time so there is no double booking. Our staff is trained to bring you the best possible dental care.
- To be honest. We only recommend treatment for our patients that we would have ourselves.
- To be respectful. We base our success on the quality of the relationship we have with each patient, not just the quality of the dental service we provide.
- To be responsible. We use only the best materials and dental labs. Our instruments go through sterilization in a steam autoclave that is tested regularly. All services are rendered with the latest techniques available reflecting our commitment to continuing education courses. We also recycle in order to be gentle to our environment.

We know that your time is valuable and we strive to be on time and keep any waiting to a minimum. In return we require a 48 hour notice in the event you cannot keep your appointment. Failure to do so can result in a minimum $50.00 fee to your account.

AUTHORIZATION

I hereby authorize payment directly to Dr Madeline Utterback of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. Any and all appeals to insurance will be handled by me. Non insurance payments are due at the time of service. I hereby authorize Dr Madeline Utterback to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and my health history are correct to the best of my knowledge. I grant to this practice the right to release my records/health history and information about my dental treatment to third party payers and/or other health professionals by any method including electronic transfer.

Patient or Responsible Party Signature_____ **Date**_____

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DENTAL AND HEALTH INFORMATION

Patient Name_____ Date_____

It is important that we know about your dental and health history. Many conditions have a direct bearing on your oral health. We will review the questionnaire and discuss it with you. Information which you give us is strictly confidential and will not be released without your permission. Thank you for your cooperation.

DENTAL INFORMATION

Please describe any specific dental problem or discomfort you are having at this time: _____ How long has it been present? _____

If you have had any of the following dentalcare please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery_____
"Braces" or any type of orthodontic treatment_____
Any other type of oral surgery_____

Date of Last Dental Examination:_____ Previous Dentist: _____

Have you ever had a serious injury to your face, head or teeth? _____Yes _____No

If yes, please explain:_____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

_____ Sensitive Teeth to cold, hot, sweet, or biting
_____ An unpleasant taste or persistent bad breath
_____ Does food catch between your teeth
_____ Do your gums bleed when brushing
_____ Red, swollen, tender, bleeding, or sore gums
_____ Gums that have pulled away from the teeth
_____ Pus between the teeth and gums
_____ Avoid any area when brushing or chewing
_____ You clench or grind your teeth

_____ A Clicking, snapping or difficulty when chewing
_____ Difficulty opening or moving the jaws
_____ Difficulty speaking or changes in your voice
_____ Difficulty moving your tongue or "tongue tied"
_____ Loose or separating teeth
_____ Changes in the way your teeth fit together
_____ A color change of the tissues in your mouth
_____ Any lumps, swelling or swollen glands
_____ Sores, ulcers, or rough spots in your mouth

Do you Smoke?	_____Yes	_____No
Do you consume alcohol?	_____Yes	_____No
Do you gag easily?	_____Yes	_____No
Do you snore?	_____Yes	_____No
Do you feel your teeth could be whiter?	_____Yes	_____No
Have you experienced waking up choking?	_____Yes	_____No

Please share with us anything that will help us to make you more comfortable during your dental appointment, including any special needs

_____

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HEALTH INFORMATION

Pharmacy Name: _____ Phone: _____ City:_____

Primary Physician: _____ Phone: _____ City:_____
Date of last physical examination:_____

Other Physicians & Specialist
Name: _____ Specialty: _____ Phone: _____ City: _____
Name: _____ Specialty: _____ Phone: _____ City: _____

1. Within the last 3 years, have you been hospitalized or had surgery? ☐ Yes ☐ No
If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY **medications** or take ANY special precautions **before any dental appointment**? ☐ Yes ☐ No

3. Are you **taking any drugs, medications, or treatments** at this time? ☐ Yes ☐ No
(If you have a complete written list with you, give that to the receptionist instead)

Prescribed: _____
_____
Over the Counter (OTC) medications (such as Aspirin, Advil, allergy medication, etc):
_____
Vitamins, natural or herbal preparations and/or dietary supplements:
_____

4. Are you taking or have you ever taken Fosamax? ☐ Yes ☐ No

5. Are you **allergic** to or have you ever experienced an unusual reaction to:
_____Latex _____Metals or jewelry _____Dental anesthesia (local)
_____Fluoride _____Nitrous oxide (laughing gas) _____General anesthesia

6. Are you **allergic** to or have you ever had any reactions to any of the following drugs?
_____Penicillin (or related drugs) _____Tranquilizers (Valium) _____Tetra cycline
_____Aspirin / Ibuprofen (Advil, Motrin, Nuprin) _____Keflex (Cephalexin) _____Sulfa drugs
_____NSAID (Celebrex, Vioxx, Anaprox) _____Clindamycin (Cleocin) _____Erythromycin
_____Codeine _____Iodine _____Amoxicillin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ☐ Yes ☐ No
If yes, please list: _____

8. Do you have, or have you ever had, any of the following? (Please check what applies)

_____Anemia
_____Arthritis
_____Any artificial joint, joint surgery, or prosthesis
If yes, what joint or area: _____
When was operation done: _____
_____Asthma
_____Blood Disease / Hemophilia
_____Any form of cancer, Tumor, Radiation Treatment
_____Cerebral palsy
_____Diabetes or blood sugar problems
_____Dizziness, Fainting
_____Epilepsy or other seizure disorder
_____Excessive bleeding from any cut or incident
_____Glaucoma or any eye diseases
_____Head Injury
_____Heart surgery, type & date_____
_____Heart attack, date_____
_____Congenital heart defects
_____Angina or chest pains
_____Atherosclerosis
_____Congestive heart failure
_____Coronary artery disease
_____Infective Endocarditis
_____Heart valve(s) damage / Mitral valve prolapsed
_____Artificial heart valve
_____Hepatitis, jaundice, or other liver problems
_____High Blood Pressure
_____A compromised immune system
(Lupus, HIV, AIDS, etc)
_____Any kidney problems
_____Low Blood Pressure
_____Any mental health issues
_____Been treated for any psychiatric condition
_____Multiple sclerosis
_____An organ transplant
_____Pacemaker
_____Respiratory Problems
_____Sinus problems
_____Skin problems
_____Ulcers, acid reflux, or stomach problems
_____Stroke or CVA
_____A Thyroid problem or disease
_____Tuberculosis, emphysema or lung disorder
_____An active sexually transmitted disease (STD)

Women Only:
_____Are you pregnant, due date: _____
_____Do you think you might be pregnant
_____Are you presently nursing
_____Are you using birth control medication
_____Are you taking hormone replacement theraphy

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? ☐ Yes ☐ No
If Yes, please explain:_____
_____
_____

Consent – To the best of knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.
I understand there are no guarantees or warranties in health or dental care.

Patient or Responsible Party Signature_____ **Date**_____

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PATIENT HIPAA AWARENESS

With my permission, Dr. Madeline Utterback may use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operations (TPO). Please refer to Dr. Madeline Utterback Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Madeline Utterback reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Madeline Utterback may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Madeline Utterback may mail to my home or other designated locations any items that assist the practice in carrying our TPO, such as appointment reminders cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Dr. Madeline Utterback may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Madeline Utterback restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Madeline Utterback to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date

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CONSENT TO DENTAL PHOTOGRAPHY

I, _____, hereby authorize Dr Utterback and her staff, to disclose facial and/or dental photographs of the following patient as approved below:

Patient Name: _____ **Patient DOB:** ____ /____ /____

Please check the appropriate answer to each of the following questions:

1. May the patient's picture be displayed on the reception desk computer screen for patient sign-in purposes?
   ____ **Yes** ____ **No**

2. May the patient's picture be displayed on the office website, Facebook account and/or within the office for the purpose of informing patients of the positive outcome we have achieved?
   ____ **Yes** ____ **No**

3. May the patient's picture be displayed on the office website, Facebook account and/or within the office if they are a contest prize winner?
   ____ **Yes** ____ **No**

4. May the patient's photographs be used for the purposes of professional consultations, research, education, or publication in professional journals?
   ____ **Yes** ____ **No**

Please note:

Financial Disclosure: I understand that neither the patient nor the dental practice will receive compensation from anyone for use of the patient's photo.

Refusal to Sign: I understand that refusal to sign part or all of this authorization will in no way affect the patient's treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed at the time the revocation is received.

Certification:

I certify that I am the authorized representative for the patient. My relationship with the patient is: _____

I certify that I am the patient or the representative.

Signature: _____ Date: _____

Witness: _____ Date: _____