Artistic Dental
at the biltmore

We are pleased to welcome you to our practice!

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and possibly be given additional questions regarding your health. This information is vital to allow us to provide appropriate care for you. This office does not use this form to discriminate.

How did you hear of our office? ☐ **Friend/Family, please list name** _____
☐ **Ad/Coupon** _____ ☐ **Insurance** _____ ☐ **Internet search (Google/Yelp, etc.)** _____
☐ **Location/Sign** ☐ **artisticd.com** ☐ **Other** _____

General Patient Information

Please provide some basic information.

Patient Name _____ **Pref. Name** _____
Last **First** **Middle Initial**

Date of birth _____ **SSN** _____ **Sex** ☐M ☐F ☐ **Single** ☐ **Married** ☐ **Child**

Address _____
Street or PO Box City State Zip

Best Contact # _____ **Work #** _____ **Email** _____

Have any of your family members been to our office before? ☐ **Yes** ☐ **No** **If yes, please provide name** _____

Occupation/student _____ **Where** _____

Emergency contact _____ **Relationship** _____ **Phone #** _____

**If you are completing this form for someone else, what is your relationship to that person?*

Your Name _____ Relationship_____

Insurance

If you have insurance, please fill out the information below and sign the insurance agreement. This allows our office to send dental claims on your behalf and process payments.

Primary Insurance
Insured's Name: _____
Insured's date of birth: _____
SSN# or ID #: _____
Insurance Co: _____
Insurance Phone#: _____
Group #: _____
Employer: _____

Secondary Insurance
Insured's Name: _____
Insured's date of birth: _____
SSN# or ID #: _____
Insurance Co: _____
Insurance Phone#: _____
Group #: _____
Employer: _____

I certify that the above insurance information is correct and in force. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I hereby authorize Artistic Dental, Insurer, or other organization to release any information regarding the dental history, treatment, or benefits payable for the dental claims of the Plan administrator or its authorized agent for determining benefits payable. I understand that I am financially responsible for care provided and that insurance is considered a method of reimbursement and is not a substitution for payment. I authorize my signature to be on file for the processing of dental claims on my or my family's behalf and authorize benefits to be paid directly to Artistic Dental at the biltmore, Inc. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitation and exclusions. I understand that deductibles, co-payments, and non-covered services are my responsibility to pay by the time of service and that the treatment plans given by Artistic Dental are only an estimate of benefits and co-payments.

_____ _____
Signature **Date**

Office Polices to Read, Acknowledge, Sign and Date

We need to make you aware of a few policies we abide by in our office and need your consent to treat you.
If you have any questions, please ask! Thank you for your cooperation.

Policy regarding Same-Day Cancellations

I understand that Artistic Dental has a $50 fee/hour that may be applied to my account if I miss an appointment without sufficient notice to the dental office of at least 24 hours prior to my scheduled appointment time. I am enrolled in an automated appointment reminder system that will help avoid the unfortunate forgetting of an appointment and I can modify my method of contact at any time, but ultimately take the responsibility of scheduling responsibly.

Financial Responsibility

If my account becomes delinquent (60 days or older), I agree to pay all late fees, finance charges, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.
To avoid collection action, I will keep in contact with the office when I receive correspondence from them regarding balances.
Returned checks will be assessed a $30 non-sufficient funds charge.

Acknowledgment of Receipt of Privacy Notice

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

Consent for Treatment

I, the undersigned, hereby authorize and understand that for the doctors of Artistic Dental at the biltmore to properly diagnose my/or my dependents' dental condition(s), he/she will need to have a thorough medical and dental record compiled, which includes, but is not limited to: radiographs, study models, photographs or any other diagnostic aids the office employs.
I understand I will have the opportunity to ask questions at any time regarding my diagnosis, recommended treatments, attendant risks and complications, post-operative course and variables, and treatment alternatives; including doing nothing at all, and have my questions answered to my satisfaction.
I understand I will be informed of unexpected treatments that may be necessary, in the judgment of the doctor to improve my safety and result during treatment. Although favorable results are expected, no guarantee or warranty of expectations, refunds of any kind, either expressed, or implied, will be made. This is due to the human variable associated with individual healing and recovery responses to treatment of any kind.
I understand that my doctors at Artistic Dental are very much involved in the use, research, and advancement of new technologies, procedures and materials and may employ these advancements to deliver my treatment.
I understand that excellent home care by me/my dependent, will add considerably to the successful outcome of treatments and my/their dental health.

I have read all the above and consent for treatment prior to my signature and understand in full. I authorize the Artistic Dental doctors and team to proceed with the diagnosis and the necessary treatment as will be proposed, following the establishment of financial arrangements. If dental insurance is involved, I understand that I am ultimately responsible for my account and any balances not covered by my insurance. I also state that I read and write in English.

_____ _____

Patient/Parent/Guardian Signature **Date**

Dental and Medical Health History

Patient Name _____ **Date of birth** _____

Dental Information

	Yes	No
Are you currently experiencing dental pain?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Are your teeth sensitive to sweet and pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any past problems associated with having dental treatment?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you jaw clicking, popping or discomfort?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever had serious injury to your head? or mouth?	☐	☐

Date of your last dental exam _____ **Were x-rays taken?** ☐**Yes** ☐**No**

Previous Dentists Name _____ **Office #** _____

If you would like us to request your dental records, please sign _____ **date** _____

List one thing you like about your smile _____

List one thing you don't like about your smile _____

Health History Information

Physician Name _____ **Office #** _____

Pharmacy _____ **Phone #** _____

Are you in good health? ☐**Yes** ☐**No** **If you've answered No**
Are you under a physician's care now and what for? _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐**Yes** ☐**No**
If yes, what for? _____

Please list all Medications / vitamins / supplements that you are currently taking

_____

_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐**Yes** ☐**No**

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
☐**Yes** ☐**No** **Date treatment began** _____

Allergies Are you allergic to or have you ever had a reaction to:

	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics _____	☐	☐
Iodine	☐	☐
Latex	☐	☐
Metals	☐	☐
Other _____	☐	☐

If any yes responses, please specify type of reaction _____

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Please check mark a yes or no response to indicate if you have or have not had any of the following health concerns or diseases

	Yes	No
Allergies: Seasonal/Food/Animals/Other _____	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Arteriosclerosis	☐	☐
Asthma	☐	☐
Autoimmune disease	☐	☐
Back Problems	☐	☐
Blood disease	☐	☐
Bleeding, abnormal	☐	☐
Blood transfusion, if yes when? _____	☐	☐
Bronchitis/Pneumonia	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐
Type _____		
Cardiovascular disease	☐	☐
Chemical dependency	☐	☐
Circulatory Problems	☐	☐
Congestive heart failure	☐	☐
Cortisone Treatments	☐	☐
Damaged heart valves	☐	☐
Diabetes Type I or II Glucose # _____	☐	☐
Do you snore?	☐	☐
Do you wear contacts?	☐	☐
Eating Disorder	☐	☐
Eye Condition, other than corrective lenses	☐	☐
Emphysema	☐	☐
Epilepsy/seizures	☐	☐
Dizziness, fainting spells	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Glaucoma	☐	☐
Head Injury	☐	☐
Hearing loss	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Hemophilia	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
High blood pressure	☐	☐
HIV infection or AIDS Viral load _____	☐	☐
Joint Replacement (hip, knee, elbow, etc)		
Date: _____ Complications ☐**Yes** ☐ **No**		

	Yes	No
Kidney problems	☐	☐
Low blood pressure	☐	☐
Malnutrition	☐	☐
Mental health disorders	☐	☐
Specify please _____		
Mitral valve prolapse	☐	☐
Neurological disorders	☐	☐
Specify please _____		
Night sweats	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Respiratory Problems	☐	☐
Recurrent infections	☐	☐
Type of infection _____		
Persistent cough	☐	☐
Rheumatoid arthritis	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Severe or rapid weight loss	☐	☐
Severe headaches/migraines	☐	☐
Sleep disorder	☐	☐
Skin Condition	☐	☐
Stroke	☐	☐
Systemic lupus erythematosus	☐	☐
Swollen glands in neck, persistent	☐	☐
Thyroid problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐

Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommend for any form of CHD.

Regarding the joint replacement, did your Orthopedic surgeon give instruction to pre-medicate with antibiotics before dental treatments? ☐ **Yes** ☐ **No** ☐**Don't Know**

Do you use tobacco products (smoking, snuff, chew, bidis)? ☐**Yes** ☐**No**
If so, how interested are you in stopping? Check one: ☐Very ☐Somewhat ☐Not Interested

Women Only Are you: Taking birth control pills or hormonal replacement? ☐**Yes** ☐**No**
Pregnant? ☐ **Yes** ☐**No** Number of weeks along _____ Nursing? ☐ **Yes** ☐ **No**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on the information for treatment me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have mad in the completion of this form.

_____ _____

Patient/Parent/Guardian Signature **Date**

Notes: _____