The Loft DENTAL STUDIO
General·Cosmetics·Implants

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

What is your preference of communication? Email ❑ Phone ❑ Text ❑	Social Security no:	Cell phone no.: ( )

Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary Medical insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate primary Dental insurance:

Subscriber's name: DOB: / / SSN:

Group # Insurance Phone Number:

Please indicate Secondary Dental Insurance:

Subscribers Name:	DOB / /	SSN:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The loft dental studio clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Medical History

Are you in good health? Yes ☐ No ☐ Do you Smoke or use tobacco? Yes ☐ No ☐

(Please Check)

Y	N	Conditions:	Y	N	Conditions:	Y	N	Conditions:
☐	☐	Abnormal Bleeding	☐	☐	Pneumocystis	☐	☐	Sinus Problems
☐	☐	Hemophilia	☐	☐	Tuberculosis	☐	☐	Sleep Apnea
☐	☐	Anemia	☐	☐	Chemotherapy	☐	☐	Bruxism
☐	☐	Blood Transfusion	☐	☐	Radiation Therapy	☐	☐	Thyroid Problems
☐	☐	Alcohol Abuse	☐	☐	Cosmetic Surgery	☐	☐	Ulcers
☐	☐	Heart Attack/Stroke	☐	☐	Diabetes	☐	☐	Venereal Disease
☐	☐	Angina Pectoris	☐	☐	Drug Abuse	☐	☐	Bisphosphonates
☐	☐	Artificial Heart Valve	☐	☐	Epilepsy/Seizures	☐	☐	Osteoporosis
☐	☐	Heart Disease	☐	☐	GERD/Acid Reflux	☐	☐	Xerostomia/Dry Mouth
☐	☐	Congenital Heart Defect	☐	☐	Fainting Spells	☐	☐	Sjogrens Syndrome
☐	☐	Mitral Valve Prolapse	☐	☐	Fever Blisters	☐	☐	Prostate Problems
☐	☐	Rheumatic Fever	☐	☐	Frequent Headaches	☐	☐	Parkinsons Disease
☐	☐	Pace Maker	☐	☐	Glaucoma	**Y**	**N**	**Allergies**
☐	☐	Low Blood Pressure	☐	☐	Hepatitis A B C	☐	☐	Dental Anesthetics
☐	☐	High Blood Pressure	☐	☐	Benign Tumor Or Growth	☐	☐	Erythromycin
☐	☐	Cholesterol	☐	☐	Cancer Type:	☐	☐	Jewelry
☐	☐	Arthritis/ Rheumatoid/ Osteoarthritis	☐	☐	HIV / AIDS	☐	☐	Latex
☐	☐	Prosthetic Replacement	☐	☐	Kidney Problems	☐	☐	Metals
☐	☐	Allergies	☐	☐	Liver Disease	☐	☐	Penicillin
☐	☐	Asthma	☐	☐	Psychiatric Problems	☐	☐	Tetracycline
☐	☐	Esophagitis	☐	☐	Shingles	☐	☐	Aspirin
☐	☐	Difficulty Breathing	☐	☐	Sickle Cell Disease	☐	☐	Codeine
☐	☐	Sexually Transmitted Disease	☐	☐	Fibromyalgia			

Medications:

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes please describe below.

If Female please answers the following:

Y	N	
☐	☐	Are you taking Birth Control Pills
☐	☐	Are you Pregnant? If yes # of weeks_____
☐	☐	Are you Nursing?

For office use only
BP: Heart Rate:

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting of Chewing?	Yes	No
Have you noticed any mouth odors or Bad tastes?	Yes	No
Do you frequently get cold sores, Blisters or any other lesions?	Yes	No
Do your gums bleed or Hurt?	Yes	No
Have your parents experienced gum Disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No

Does food tend to become caught in between your teeth?	Yes	No
HAVE YOU EVER HAD		
Orthodontic treatment?	Yes	No
Oral Surgery	Yes	No
Periodontal Treatment?	Yes	No
Your Bite Adjusted?	Yes	No
A bite or mouth guard?	Yes	No
A serious injury to mouth or head?	Yes	No

If so, please describe _____
_____
_____

Do you:

Clench or grind your teeth while awake Or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco Products?	Yes	No

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Are you satisfied with your teeth	Yes	No
Are you nervous about dental treatment?	Yes	No

If so, what is your biggest concern?_____
_____

Have you ever had an upsetting dental Experience?	Yes	No

If yes, please describe_____
_____

Medical:
In an effort to access your medical benefits and gain maximum reimbursement for you we need your assessment and details of physical and mental health. This information will be used to gain proper authorization for your procedures. Please be detailed in your responses.

Personal History — Please tell us your main concern and what you feel has lead you to this condition, and how long have you had these conditions?

Medical History — List past and present surgeries/ procedures

Function — How has this condition affected your ability to function normally and how has it affected your health?

Diagnosis — Have you been or are you presently diagnosis and being treated with any condition that has affected your physical and mental health?

Authorization procedures. — I consent to allow the office to share medical information with the insurance company to help support medical necessity for my procedures.

Patient Name Printed _____

Patient Signature: _____

Date: _____

Physician Name:	Physician Phone #

Pharmacy:	Pharmacy Phone #

Medical Information Release

Your signature is necessary for us to:

- PROCESS ALL INSURANCE CLAIMS
- ENSURE PAYMENT FOR SERVICES RENDERED
- RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES WHEN NECESSARY FOR YOUR TREATMENT.
- PROVIDE EXCELLENT DIAGNOSTIC AND PREVENTIVE CARE

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits, to which I am entitled to Dr. _____. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____

Oral Cancer Screening Option

Oral Cancer screenings are advised every year for our patients. If you are choosing to decline the service, please sign below to waive the right for the cancer screening. It is a right you have to decline services and we are giving you the choice now.

This option to NOT receive or be charged for the oral cancer screening will remain in effect until revoked by me in writing.

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____

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Acknowledgement of receipt of

Notice of privacy policies

I _____, have received a copy of

The Loft Dental studio notice of Privacy Policies.

_____

Name (Please print)

_____ _____

Signature Date

Office use only

On _____ , An acknowledgement of receipt of notice of privacy policies form was delivered .The form was not signed due to:

☐ Communication Barriers which prevented acknowledgement
☐ An emergency which prevent acknowledgement
☐ A refusal to sign
☐ Other _____

This information is intended as advisory in nature and should be considered as legal advice nor is it a substitute for legal advice .This information does not constitute technical systems /security advice .It is designed to assist you in your own risk management activities .It is not intended to be exclusively relied upon or used as a substitute fro your own loss-control program.
Accuracy and completeness are not guaranteed.

The federal HIPPA privacy compliance requirements are explained in this binder .When you develop your HIPPA compliance policy, Incorporate whatever is necessary to address state law requirements as well.