Sneath Family Dentistry
Dr. Brian Sneath DMD
720 W County Rd., Jerseyville
618-498-9822

Confidential Patient Information

Please Print
Date: _____ Referred by: _____

PERSONAL INFORMATION
Name: _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone (Cell) _____ (Home) _____ (Work) _____
Birthdate: _____ Sex: _____ Marital Status: _____ Spouse name: _____
Employer: _____ Occupation: _____ Email: _____

PERSON RESPONSIBLE FOR ACCOUNT *(if different than above)*
Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Cell) _____ (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION
Primary Insurance Co. Name & Phone #: _____
Employee: _____ Date of Birth: _____ ID# or SS#: _____
Relationship: _____ Policy/Group#: _____
Employer Name and Address: _____

Secondary Insurance Co. Name & Phone #: _____
Employee: _____ Date of Birth: _____ ID# or SS#: _____
Relationship: _____ Policy/Group#: _____
Employer Name and Address: _____

Person to contact in case of Emergency

Name: _____ Relationship: _____
Address: _____
Telephone: (Home) _____ (Cell) _____

Medical History

**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.

Personal Physician Name and #:_____

Personal Physician Address: _____

YES/NO Are you currently taking any blood thinners ? If yes, explain_____

YES/NO Have you been hospitalized within the past 2 years? If yes, explain _____

YES/NO Are you currently being treated by a physician? If yes, explain _____

Please list ALL medicines, drugs, vitamins/minerals &/or supplements you are currently taking: _____

_____

_____

YES/NO Do you smoke/use smokeless tobacco? If yes, how much? _____

YES/NO Do you drink alcohol? If yes, how much? _____

YES/NO Have you ever received counseling for excessive use of alcohol or prescription drugs?

YES/NO Do you have any **artificial joints** or **heart valves**? If yes, what & when? _____

YES/NO Did physician/surgeon recommend antibiotic premedication prior to dental appointments?

Are you **Allergic** to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Dental anesthetic □ Metal □ Latex □ Sulfa Drugs

□ Other If yes, please explain _____

YES/NO Are you pregnant?

YES/NO Are you taking (or have you ever) bisphosphonates for osteoporosis? _____

YES/NO Have you had IV therapy for multiple myeloma, metastic cancer, Paget's disease or osteoporosis?

	Yes	No		Yes	No
Acid Reflux	□	□	High Blood Pressure	□	□
AIDS	□	□	High Cholesterol	□	□
Angina	□	□	Kidney Problems	□	□
Arthritis	□	□	Low Blood Pressure	□	□
Artificial Bones/Joints	□	□	Neck Problems	□	□
Asthma	□	□	Nervous Disorder	□	□
Back Problems	□	□	Osteoporosis	□	□
Cancer	□	□	Parkinson's Disease	□	□
Chemotherapy	□	□	Psychiatric Therapy	□	□
Depression	□	□	Radiation Treatment	□	□
Diabetes	□	□	Respiratory Problems	□	□
Epilepsy	□	□	Rheumatic Fever	□	□
Glaucoma	□	□	Sexually Transmitted Disease	□	□
Heart Problems	□	□	Stroke	□	□
Hepatitis	□	□	Tuberculosis	□	□

Other: _____

If yes to any of above, please explain: _____

Dental History

Date of last dental exam: _____

Are you currently in pain? Yes/No If yes, how long? _____

	Yes	No	
Do your gums bleed when you brush/floss?	□	□	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	□	□	Where? _____
Do you grind or clench your teeth?	□	□	_____
Do you have any clicking popping, or jaw discomfort?	□	□	_____
Do you have lost or broken fillings?	□	□	_____
Do you have broken or chipped teeth?	□	□	_____
Does food collect between teeth?	□	□	_____
Bad Breath?	□	□	_____
Dry Mouth?	□	□	_____
Loose teeth?	□	□	_____
Do you drink soda?	□	□	If yes, how often? _____
Have you had periodontal (gum) treatments?	□	□	If yes, when? _____
Have you had orthodontic (braces) treatments?	□	□	_____
Do you have sores or ulcers in your mouth?	□	□	_____
Do you wear dentures or partials?	□	□	_____

How often do you brush? _____ How often do you floss? _____

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

_____

Is there anything else you feel we should be aware of prior to dental treatment? Yes/No

If yes, please explain _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement. I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance, for myself, or above named patient, unless other financial arrangements are approved. I also agree to pay for all costs of collection, including attorney fees, and court cost, should additional means of collection be required.

My signature on this form also gives Dr. Sneath and his staff authorization to treat my dental needs.

Signature: _____ Date: _____

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 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 your 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 a 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 notices of your revocation submitted to the Contact Person listed above. 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.

I, (print full name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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, payment activities and health care operations.

Signature _____ **Date:** _____

If this Consent is signed by someone other than patient, complete the following:

Representative's Name: _____ **Relationship to Patient:** _____

I give consent for the following people to discuss my personal health information with my dental practitioner and his staff

Name(s) _____

I give consent for the following people to discuss my financial information with my dental practitioner and his staff.

Name(s) _____