Livingston Dental

800 South Washington
Afton , WY 83110
307-885-4337

124 Petersen Parkway Suite #3
Thayne, WY 83127
307-883-4337

1 About You

Today's Date:____/___/____

Patient Name: ______________________________

What you Prefer to Be Called:__________ ☐Male ☐Female

Birth date:___/___/____ Age:____ SS#: ______________

Mailing Address:

____

____

Home Phone#:(_____) ______________________

Work Phone#:(_____)_______________________

Cell Phone#: (_____) ______________________

E-mail Address:_____________________________

Referred By:________________________________

Employer:___________________ How Long?__________

Employer's Address:__________________________

____

Occupation:_________________________________

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:______________________________

Do you have children? ☐Yes ☐No How Many?__________

Do You Have Dental Insurance? ☐Yes ☐No (If Yes Please provide front office personnel with card so they can photocopy it.)

Insurance Agreement: I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. 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 understand that an estimated potion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

______________________________ __________

Signature of responsible party **Date**

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2 Account Information

Person Ultimately Responsible for Account

Name:_____________________________________

Relation:____________________________________

Billing Address: _____________________________

____

SS#:______-_______-______ DOB: ____/___/______

Work Phone#:(____)__________________

Payment Method: ☐ Cash ☐ Check

☐**Credit Card (please put card info below)**

Card # ______________________________

___/___ exp 3 digit code from back ____

☐**Care Credit** (Please put card info below)

Card#______________________________

PLEASE INITIAL

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

_____I hereby authorize that any unpaid balance that my insurance benefits did not pay to be charged to the credit card, or Care Credit # listed above.

3 In Event of Emergency

Whom should we contact?______________________

Relation______________________________________

Phone (____)__________ Cell (____)______________

Who is your Medical Doctor?___________________

Medical Doctor's Phone #:(____)_________________

4 Dental Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation

Are You in pain? ☐No ☐ Yes How Long?_____

Please indicate ☑ any of the following problems:

☐Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth

☐Red, swollen or bleeding gums. ☐ Teeth Grinding ☐ Locking Jaw

☐Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad Breath

☐Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth/teeth

☐Other:_____

Do you require pre-medication? ☐ Yes ☐ No ☐ I don't know

Previous Dentist:_____ Phone (___)_____

Last Dental Exam:___/___/___ Last Dental Xray: ___/___/___

Times a day you brush?_____ Times a week you floss?_____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

5 Medical History

What medications are you taking? ☐Nerve Pills ☐Pain Killers (including aspirin) ☐Muscle relaxers ☐Stimulants ☐Blood Thinners ☐Tranquilizer ☐Insulin ☐Meds for Osteoporosis .

Others:_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery	Y N Heart Surg./ Pacemaker
Y N Kidney Problems	Y N Shingles	Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis A / B / C
Y N Chemotherapy	Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems/Nose Bleeding	Y N Arthritis/Rheumatism	Y N Difficulty Breathing/COPD	Y N Artifical Valves
Y N Artificial Bones/ Joints	Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Seizures/Epilipsy?fainting	Y N Anemia	Y N Chest Pains
Y N Alcohol/Drug Abuse	Y N Frequent Headaches	Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain
Y N Bleeding Problems	Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma
Y N Stomach Problems	Y N Diabetes/Hypoglycemia	Y N High/Low Blood Pressure	Y N Xray or Cobalt Treatment	Y N Dry Mouth/Cold Sores

Please list any other surgeries or medical conditions you have had or ever have had:

_____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Foods:_____ ☐Others:_____

Do you use tobacco? ☐Yes ☐No (If Yes) How used?_____ How much?_____ How Long?_____

Please rate your general health from 1-10:_____ Are you pregnant? Y N_____

We Invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Financial Coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We file insurance as a courtesy to you and amounts quoted are only an estimate. Patient is responsible for entire balance regardless of insurance.

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that my be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date: _____

Livingston Dental **ph: 307-885-4337**
Patient Authorizations **fx: 307-885-4334**

_____ I authorize the release of my dental records from Livingston Dental and/or individuals involved in my dental care. I further authorized the release of records from any individuals to Livingston Dental.
_____ I authorize insurance payments to be made directly to Livingston Dental. I understand I am responsible for any unpaid balance.
_____ I am aware that should I not provide adequate notice to change a reservation, I may be charged a fee. (7 calendar days for a surgical reservation and 2 business days for a cleaning reservation or exam.)
_____ I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPPA)

Notice of Privacy Practice- Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your records or get more information about it by contacting us.
Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Reservation Confirmation & Office Communication
As a courtesy to our patients, we often will give a variety of reservation reminders. Some of these reminders may generally include, but are not limited to, reservation post-cards sent through the mail, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's reservation time and date, or need for a reservation may be included. To respond to the text message, simply type YES and send. We receive the response and will mark you as confirmed.

As my signature below, I authorize Livingston Dental and staff to confirm my reservation and remind me of the need for a reservation in the above-mentioned ways, for the duration of my treatment with their office.

Authorize to Discuss Treatment & Financial Information

By my signature below, I authorize Livingston Dental and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.
Name:_____ **Relationship to Patient:**_____ **Cell Phone:**_____
Name:_____ **Relationship to Patient:**_____ **Cell Phone:**_____

- o I do not authorize Livingston Dental to discuss treatment and financial information with anyone other than myself.

Patient's Signature:_____ **Date:**_____

TruDenta®
Life Changing Dentistry

1) Do your jaw muscles get tight or sore? Yes_____ No_____
When? Morning____ Evening____ After chewing____

2) Are you aware of noises in your jaw joints? Yes_____ No_____
Popping____ Clicking____ Other____
Where? Right____ Left____ Both____
How long? Less than 1 year____ More than 1 year____

3) Do you grind or clench your teeth? Yes_____ No_____
Do you wear a? Splint____ Night Guard____ Retainer____

4) How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication?
Occasionally____ More than twice a year____ More than once a month____
More than once a week_____ Never____

5) How many days per month are you:
Pain Free?_____ Headache Free?_____