Travis A. Markle D.D.S., PLLC

Family and Cosmetic Dentistry

Welcome

1 About You

Name _____

Preferred Name _____ Male Female

Single Married Divorced Widowed Separated

Birthdate ___/___/___ Age ____ SS# _____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Cell # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Employer _____ Phone # _____

Employer Address _____

_____

How long employed there? _____

2 Account Info

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Cell # _____ Birthdate ____ / ___ / ____

Email _____

Billing Address _____

City _____ State _____ Zip _____

3 Spouse Info

Name _____

Home # _____ Work # _____

Cell # _____ Birthdate ____/____/____

Email _____

4 Dental History

Why have you come to the dentist today? _____

_____

_____

Has your doctor told you that you require antibiotics before dental treatment Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of toothbrush bristles? Hard Medium Soft

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

5a Medical History

Your current physical condition Good Fair Poor

Do you smoke or use tobacco? Yes No

Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No

Please list each one _____

_____

Have you ever taken Phen-Fen? Yes No

(also known as Redux or Pondimin) if yes, when?

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes No | Abnormal Bleeding
Yes No | Alcohol / Drug Abuse
Yes No | Anemia
Yes No | Arthritis
Yes No | Artificial Bones, Joints, | or Valves
Yes No | Asthma
Yes No | Blood Transfusion
Yes No | Cancer / Chemotherapy
Yes No | Colitis
Yes No | Congenital Heart Defect
Yes No | Diabetes
Yes No | Difficulty Breathing
Yes No | Emphysema
Yes No | Epilepsy
Yes No | Fainting Spells
Yes No | Frequent Headaches
Yes No | Glaucoma
Yes No | Hay Fever
Yes No | Heart Attack
Yes No | Heart Murmur
Yes No | Heart Surgery
Yes No | Hemophilia
Yes No | Hepatitis
Yes No | Herpes/ Fever Blister
Yes No | High Blood Pressure
Yes No | HIV+ / AIDS
Yes No | Hospitalized | for any reason
Yes No | Kidney Problems
Yes No | Liver Disease
Yes No | Low Blood Pressure
Yes No | Lupus
Yes No | Mitral Valve Prolapse
Yes No | Pacemaker
Yes No | Psychiatric Problems
Yes No | Radiation Treatment
Yes No | Rheumatic / | Scarlet Fever
Yes No | Seizures
Yes No | Shingles
Yes No | Sickle Cell Disease
Yes No | Sinus Problems
Yes No | Stroke
Yes No | Thyroid Problems
Yes No | Tuberculosis (TB)
Yes No | Ulcers
Yes No | Venereal Disease

Please list any other medical conditions you may have_____

_____

_____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

5b Medical History

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes No | Aspirin Yes No | Penicillin Yes No | Dental Anesthetics
Yes No | Codeine Yes No | Jewelry /Metals
Yes No | Latex Yes No | Other

Please list any other drugs/materials that you are allergic to

_____

Do you have a personal physician ? Yes No

Physician's Name _____

Phone # _____ Last visit date _____

Are you Currently under the care of a physician? Yes No

Please explain _____

_____

IN THE EVENT OF AN EMERGENCY. WHO SHOULD WE CONTACT?

Name _____ Relation_____

Home # _____ Work # _____

Cell # _____

6 Authorization

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to Dr. Markle insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or parent/guardian Date

Photo Consent: If any before / after photos are taken of dental work performed, I give Dr. Markle permission to use photos for educational purposes and lecture presentation.

_____ _____

Signature of patient or parent/guardian Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGERMENTSHAVE BEEN APPROVED.

OFFICE USE ONLY- I verbally reviewed the medical/dental information above with patient named herein. Initials_____ Date _____

Doctor's Comments_____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Travis Markle D.D.S. PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

I, _____, have received a copy of this office's Notice of Privacy Practice.

_____
Please Print Name

_____
Signature

_____
Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtained the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

_____

_____