Afdent –Patient Medical Information   Date: ____/____/________

First Name: ____________________ **Middle:** ________ **Last Name:** ____________________

Address: ____________________ **City:** ______________ **State:** _______ **Zip Code:** _________

Primary Phone: _______-_______-__________ **Birthdate:** ____-_____-____ **Last dental visit:** ______________

Reason for visit today: ____

Employer: ____________________ **Date of Hire:** ______________ **Supervisor/HR:** ______________

In case of emergency: Name: ____________________ Relationship: ___________ Phone: ______________

List current medications: ____

____

Dr.'s Name: ____________________ **Practice Name:** ____________________ **Phone:** ______________

Specialist's Name: ____________________ **Practice Name:** ____________________ **Phone:** ______________

Allergies: __Latex __Novacaine __Aspirin __Penicillin __Codeine __Sulfa __Acrylic __Metal Other ___________

Have you ever had a reaction to local anesthetic? __Yes __No Describe: ____________________

Have you ever been treated for or informed you have:

Y N Mitral Valve Prolapse	Y N Aids	Y N High Blood Pressure	Y N Kidney Disease
Y N Rheumatic Fever	Y N HIV	Y N Low Blood Pressure	Y N Cancer-Area: _________
Y N Artificial Valves	Y N Blood Transfusion	Y N Heart Attack-Year:_____	Y N Radiation-Year: _______
Y N Artificial Joints	Y N Tuberculosis	Y N Chest Pain	Y N Chemotherapy-Year: ______
Y N Artery Stents	Y N Liver Disease	Y N Heart Disease	Y N Epilepsy
Y N Taken Phen Phen	Y N Arthritis	Y N Stroke-Year: _______	Y N Eating Disorder
Y N Diabetes	Y N Alcoholism	Y N Pacemaker-Year: _____	Y N Sinus
Y N Glaucoma	Y N Ulcers	Y N Heart Murmur	Y N Asthma/Hay Fever
Y N Hepatitis	Y N Drug Dependency	Y N Endocarditis	Y N Psychiatric Treatment
Y N VD	Y N Crohns Disease	Y N Congenital Heart Defect	Y N Do you smoke?
Y N C.O.P.D.	Y N TMJ	Y N Congenital Heart Failure	Y N Use Chewing Tobacco?

Do you take any blood thinning medications? ___Yes___ No

Have you in the past or are you currently taking a prescription bone strengthening medication? ____ Yes ___ No
If so, which?________________

List any serious illness or conditions not listed above: ______________________________

Do you wear full or partial removable dentures? ___Yes ___ No How old are they? ______________
Are you pregnant or nursing? ___Yes ___No Expected Due Date? ______________
Subject to prolonged bleeding? ___Yes ___No
Subject to fainting? ___Yes ___No
Have you worn a CPAP device? ___Yes ___No
Do you snore? ___Yes ___No

The undersigned authorizes Roger S. Pecina, D.D.S, Affiliated Family Dentists, and associates/Afdent Dental Services ("Afdent") and/or such associates or assistants designated by Afdent to perform those procedures as may be deemed necessary or advisable to maintain the dental health of the undersigned, or the dental health of any minor or other individual for whom the undersigned has responsibility, including the arrangement and/or administration of any sedative, anesthetic, analgesic, therapeutic and/or pharmaceutical agent. The undersigned further authorizes Afdent to take x-rays, study models, photographs, and/or other diagnostic measures to perform the treatment, care, and therapy, including the use and provision of medication, which Afdent deems appropriate in connection with treatment provided. The undersigned herby acknowledges and understands that the use of anesthetic agents embodies certain risks and may cause certain untoward side effects including, but not necessarily limited to, bruising, hematoma, cardiac stimulations, muscle soreness, temporary or permanent numbness. The undersigned hereby voluntarily assumes any and all possible risks, if any, which may be associated with treatment, and further acknowledges that he/she is aware of any potential risks, and has had the opportunity to ask questions in connection with treatment and/or any risk involved. Lastly, in an effort to maintain the highest level of customer service, it is Afdent's policy to record or monitor client communications including telephone calls and/or office visits for training purposes. By executing this form, the patient acknowledges Afdent's recording policy and consents to the recording and/or monitoring of his/her communications with Afdent.

Patient ______________________________ Date ____________________

Patient or Responsible Party ______________________________ Relationship to Patient ______________

AFFILIATED FAMILY DENTISTS, P.C.
605 W. DOUGLAS ROAD
MISHAWAKA, IN 46545

AUTHORIZATION TO RELEASE INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request diagnosis or treatment details and billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

This authorization is valid until you cancel it in writing.

I authorize/allow Afdent Dental Services to release my medical and/or billing information to the following individual(s):

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Patient Signature: ______________________________________ Date: ________________

Relationship to Patient: _________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have been given the opportunity to review and/or request a copy of Afdent Dental Services' Notice of Privacy Practices on the date indicated below. If you have any questions regarding the information in our Notice of Privacy Practices, please do not hesitate to contact our HIPAA Privacy Official as indicated on the Notice.

Patient Signature: ______________________________________ Date: ____________________

Relationship to Patient: _________________________________

Afdent
Roger S. Pecina and Associates

REQUEST FOR EVALUATION AND/OR TREATMENT

Welcome to Afdent! This form will provide information that is important when making educated decisions regarding treatment options. Although the benefits of treatment are usually greater than the risks, both must be considered in making your decision.

Afdent's skilled and caring staff provides the highest standard of care possible, however, there are certain risks that are inherent with any dental visit. These risks usually fall into three categories. There are expected routine post-care occurrences, occasional problems and the rare circumstances. There is also the consideration of electing to have no treatment.

ROUTINE POST-VISIT OCCURRENCES:

- Discomfort for a few days which is managed by pain medications.
- swelling
- bruising
- tooth sensitivity

OCCASIONAL PROBLEMS:

- Potential problems associated with a compromised medical history. It is very important to fully disclose all medical conditions and medications. This allows us to tailor our treatment to your unique needs and also avoid any potential drug interactions.
- Post treatment infection
- A temporary decrease in the jaw's range of motion and/or tenderness.

RARE CIRCUMSTANCES:

- Parasthesia, trauma to a nerve that is located in the area of treatment. This yields a temporary loss of effected nerve sensation. In extremely rare circumstances, there is a permanent loss of nerve sensation.
- Excessive Bleeding. Although some mild, persistent bleeding may be normal, excessive moderate to heavy bleeding may result from abnormal vascularity or decreased clotting factor.
- Allergic reactions to anesthesia or prescribed medications.
- Sinus related complications. Treatment of teeth that are in the upper jaw, which are in close proximity to the sinus, may result in sinus related trauma.

NO TREATMENT:

It is difficult to predict the result of no treatment, however most oral abnormalities will worsen with time. No treatment may result in swelling, pain, infection, cyst formation, periodontal disease, dental decay, jaw fracture or premature loss of teeth or bone.

Your signature below certifies that:

1. You understand that there are certain inherent risks with all dental procedures and that a perfect result cannot be guaranteed or warranted.
2. You understand that treatment may require that anesthetic or drugs be administered and that certain risks are inherent with the use of these drugs.
3. You understand the importance and agree to divulge all information in regards to your medical history and your current medications.
4. In many circumstances, there are many treatment options available to the patient. You understand that our doctors will provide you with treatment options that they feel best accomodate your needs. Preferences may vary between practices and practitioners. If you have concerns or questions about treatment options presented to you, please address these concerns to your doctor.
5. You understand that Afdent and our dentists will provide the highest standard of care and accepts no responsibility for complications associated with these common and inherent risks.

Please sign below to certify that you have read and understand this entire page.

______________________ Patient's Name

______________________ Date

______________________ Patient's Signature

Afdent
Roger S. Pecina and Associates™

605 W. Douglas Road • Mishawaka, IN 46545 • (574) 277-2220
(800) 325-1593 • Fax (574) 277-8108

CONSULTATION PATIENTS

I understand that my visit today includes a no obligation, no cost consultation with the Doctor where the Doctor and assistant will discuss with me my dental treatment options.

In order to **provide any treatment** today or in the future, x-rays will be taken and the Doctor will do an exam. Should I decide to proceed with treatment, I will be charged for the x-rays and exam at the time of treatment (or insurance billed if applicable). At no time will I be charged for the initial consultation.

I UNDERSTAND THAT WITHOUT X-RAYS AND AN EXAM THE DOCTOR DOES NOT HAVE ALL THE INFORMATION REQUIRED TO GIVE ME A COMPLETE DIAGNOSIS OF MY DENTAL HEALTH.

Should I decide at any time that I would like a copy of any x-ray taken whether for personal records or to be transferred to another provider, I understand that I will be charged for the cost of the x-ray and that the proper release form needs to be signed prior to x-rays being released.

____________________________ __________
Patient Signature Date