Thank you for selecting our office and allowing us the opportunity to meet with you. We take pride in our ability to provide you with the highest quality dental treatment, latest products and techniques in a warm and caring environment. We design treatment plans to meet our patient's individual needs.

We have only one treating doctor at our facility. Dr. Burton will always be the doctor that examines and treats you. Our staff consists of five people:

Cheryl & Julie can assist you in the front office
Debbie & Judy are our dental assistants
Stacy & Nikki are our registered dental hygienists
Shelly can assist with any billing questions

Your new patient visit may include the following; a comprehensive examination, a professional cleaning and any necessary diagnostic films, photographs or study models to properly diagnose and plan for your lifelong oral health and comfort.

Please bring the attached forms with you to your appointment so that we will be better prepared to meet with you. Also included are the directions to our office – please do not hesitate to call if you have any questions. Feel free to visit our web site www.OaksSmile.com for more information regarding our practice.

Sincerely,

Dr. Burton, Shelly, Cheryl, Julie, Debbie, Judy, Stacy & Nikki

Today's Date: _____

About You:

Mr./Mrs./Ms./Dr. Single/Married
Divorced/Widowed
Name: _____ Male/Female
Last First

Birthday: _____/_____/_____ Age: _____ SSN: _____ - _____ - _____

Drivers License: _____ Email Address: _____

Home Address: _____
Street City State Zip

Home Number: (_____) _____ - _____ Cell Number: (_____) _____ - _____

Work Number: (_____) _____ - _____ Ext: _____

Employer: _____ Occupation: _____

How did you hear about us? Internet/BNI/Referral/Other Referred by: _____

Other family members seen by us: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: (_____) _____ - _____

Dental Insurance Information:

Please give your card to the front desk to make a copy of as well as your Driver's License.

Insurance Company: _____ Phone Number: (_____) _____ - _____

Subscriber's Name: _____ Subscriber's Birthday: _____/_____/_____

ID Number/SSN: _____ Group Number: _____

Relationship: _____ Employer: _____

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

Consents:

I have read and I understand both the Notice of Privacy Practices and the Dental Materials Fact Sheet.
Signature: _____ Date:_____

Dental History

Why have you come to the dentist today?
_____

Are you currently in pain? Yes/No
Do you require antibiotics before dental treatment? Yes/No
Your current dental health is: Good/Fair/Poor
Do you floss daily: Yes/No Do you brush daily? Yes/No Type of toothbrush: Manual/Electric
Do your gums ever bleed? Yes/No Ever itch? Yes/No
Have you ever had periodontal disease? Yes/No
Are your teeth sensitive to: Heat/Cold/Other: _____
Do you have any loose teeth? Yes/No
Previous/Current Dentist: _____ Date of last visit: _____
Have you ever had any serious complications with prior dental treatments? Yes/No

Are you satisfied with the appearance of your teeth? Yes/No
-If No, what would you like to change? Length/Shade/Spaces/Crowding

Have you experienced any of the following?
-Clicking Yes/No
-Pain Yes/No
-Difficulty opening or closing Yes/No

Do you clench or grind your teeth? Yes/No
Have you had any orthodontic work? Yes/No

Medical History

Physician's Name: _____ Phone Number: (_____)_____-_____
Current Health: Good/Fair/Poor
Do you smoke tobacco in any form? Yes/No
Have you ever taken Phen-Fen, Redux or Pondimin? Yes/No

For Women: Are you pregnant? Yes/No/Unsure
Week: _____ Are you nursing? Yes/No

Sleep

Do you snore or have you been told you snore? Yes/No
Have you ever had a sleep apnea test? Yes/No
Have you been diagnosed with sleep apnea? Yes/No
- If yes, do you have a CPAP machine or an oral appliance? Yes/No

Are you allergic to the following?

Aspirin	Y	N	Erythromycin	Y	N	Sedatives	Y	N
Barbiturates	Y	N	Jewelry/Metals	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Penicillin	Y	N	Other	Y	N

Please list any other allergic reactions: _____
_____

Do you or have you experienced the following?

Abnormal Bleeding	Y	N	Emphysema	Y	N	Lupus	Y	N
Alcohol Abuse	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
Anxiety	Y	N	Glaucoma	Y	N	Persistent Cough	Y	N
Arthritis	Y	N	Hay Fever	Y	N	Psychiatric Problems	Y	N
Artificial Bones/Joints	Y	N	Headaches	Y	N	Radiation Treatment	Y	N
Artificial Valves	Y	N	Heart Attack	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Heart Surgery	Y	N	Shingles	Y	N
Cancer	Y	N	Hemophilia	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	Hepatitis	Y	N	Sinus Problems	Y	N
Chicken Pox	Y	N	Herpes	Y	N	Steroid Therapy	Y	N
Colitis	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Congenital Heart Defect	Y	N	High Cholesterol	Y	N	Thyroid Problems	Y	N
Depression	Y	N	HIV+/AIDS	Y	N	Tuberculosis (TB)	Y	N
Diabetes	Y	N	Kidney Problems	Y	N	Ulcers	Y	N
Difficulty Breathing	Y	N	Liver Disease	Y	N	Venereal Disease	Y	N
Drug Abuse	Y	N	Low Blood Pressure	Y	N		Y	N

Have you had any recent surgeries? Yes/No (If yes please list)
_____
_____
_____

Do you need to pre-medicate before dental appointments? Yes/No
Have you ever taken bisphosphonates? (i.e. Boniva, Actonel, Fosamax) Yes/No
-If yes, IV or Oral? _____

Prescribed Medications

Drug Name: _____ Purpose: _____ Strength: _____

Drug Name: _____ Purpose: _____ Strength: _____

Drug Name: _____ Purpose: _____ Strength: _____

E-mail and text message appointment reminders: sent three weeks & two days before, and the day of your appointment. If you opt in you are authorizing Demand Force to send these reminders to you.

Text messages: Opt in / Opt Out E-mail: Opt in / Opt Out

Authorization:

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive reimbursement. I have received a copy of this office's Notice of Privacy Practices.
We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Rodney P. Burton, DDS in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Rodney P. Burton, DDS in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Signature: _____ Date: _____

Reviewed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For many information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.