CONFIDENTIAL PATIENT INFORMATION

PLEASANT AVENUE DENTISTRY

Ben Sitz, D.D.S. • Elise Soulliere, D.D.S. • Carolyn Disse, D.D.S.

Welcome to the dental office of Dr. Ben Sitz, Dr. Elise Soulliere & Dr. Carolyn Disse!

PERSONAL INFORMATION:

Name:_____ Preferred Name:_____

Address:_____
Street City State Zip

Telephone: Home_____ Work_____

Cell_____ Can you receive texts? Yes / No

Current E-mail Address: _____

Birth Date:_____ Social Security #:_____ Sex:_____

Marital Status:_____ Spouse's Name:_____

Occupation: _____ Employer: _____

DENTAL INSURANCE INFORMATION:

Do you have dental insurance? Yes_____ No_____ **- If you do, please present your insurance card to the Office Manager at the front desk at this time.** Thank you!
Who is the subscriber of your insurance plan? (ie: spouse, mother, father, etc.) -
If someone other than yourself, please be sure that we have subscriber's birth date, social security #, employer, etc._____

I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD PARTY INVOLVEMENT, AND IS EXPECTED AT THE TIME OF SERVICE.

SIGNATURE: X_____ **DATE:** _____

(Please turn page over)

- Continued -

Personal Primary Care Physician: _____
Facility Name / Phone #: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (other than home #):

_____
Name City Phone#

DENTAL INFORMATION:

1. What is the purpose of your dental visit today?
   _____
   _____
2. Date of last dental visit ~ _____
3. Date of last x-rays taken ~ _____
4. Name of previous Dentist ~ _____
5. Do you like your smile? YES_____ NO_____
6. Would you like whiter teeth? YES_____ NO_____
7. Would you like straighter teeth? YES_____ NO_____
8. Do you or your spouse have trouble with snoring? YES_____ NO_____
9. What do you expect of us to help meet your dental goals?
   _____
   _____

How did you hear about us? We'd like to know!

Patient _____ Yellow Pages _____ Newspaper _____

Internet/Website _____ Sign outside of office _____ Other _____

SIGNATURE: X_____ DATE:_____

Time 10:15 AM

Pleasant Avenue Dentistry

Date 6/28/2022

2022 UPDATED MEDICAL HX FORM

Patient Name: Birth Date: Date Created:

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, c

Do you currently have mercury (silver fillings) that you would like removed?	◯ Yes ◯ No	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you been prescribed medications in the past 6 months / are you taking any medications now? If so,	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you take any alternative medications (supplements/herbs/vitamins)?	◯ Yes ◯ No	If yes
Do you require a premed prior to dental procedures?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing/breastfeeding? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Peanuts

Other Allergies? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Lyme Disease	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Pleasant Avenue Dentistry
Dr. Ben Sitz, Dr. Elise Soulliere, & Dr. Carolyn Disse
406 Pleasant Avenue South
Park Rapids, MN 56470
Phone (218)237-7200

CANCELLATION POLICY

We understand that sometimes appointments may need to be rescheduled. We request that you give our office at least a 24-hour notice that you will be unable to keep your scheduled appointment. We will at that time help to find a better time/date to accommodate you and then reschedule your appointment. If for any reason you cannot give a 24-hour notice, you will be charged a fee of $50.00 or more, depending upon the amount of treatment that was scheduled for that particular appointment, and the reason for canceling. We reserve specific amounts of time in our schedule for our patients, ensuring them that they will get the proper treatment and care during that time. Our patients are very valuable to us, as is our time with them. We ask that you please be considerate to this request.

*Signature X*_____ *Date* _____

OUR OFFICE PAYMENT POLICY

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. **(No exceptions unless prior approval has been made with our office staff).** We accept cash, check and any major debit/credit cards. We also have a payment plan called CareCredit, which allows you to start treatment today and spread payments over time, with the possibility of interest-free time.

Please circle the form of payment you will use to settle your account today.

PAYMENT OPTIONS:

1. CASH
2. CHECK
3. MAJOR CREDIT CARD or DEBIT CARD
4. Pleasant Avenue Dentistry PRIVATE DENTAL PLAN (ask for details)
5. CARECREDIT

Applying for CareCredit only takes a few minutes and there is no fee to apply.

If CareCredit is declined, another form of payment listed above is required at the time of service.

Signature of Patient/ Responsible Party Date

_____ _____

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Park Rapids, MN 56470
Ph. (218) 237-7200
Fax (218) 237-7201

There are no exceptions for patients with dental or medical insurance.

Pleasant Avenue Dentistry
Dr. Ben Sitz, Dr. Elise Soulliere, & Dr. Carolyn Disse

Patient Consent / Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. Ben Sitz, Dr. Elise Soulliere, Dr. Carolyn Disse, our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosure for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (218) 237-7200 and requesting a revised Notice. We will also post any revised notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

SIGNATURE(S)_____ DATE_____
*****A SIGNATURE IS NEEDED FOR EACH MEMBER OF THE FAMILY. CHILDREN UNDER THE AGE OF 18 MUST HAVE A PARENT/GUARDIAN SIGNATURE*****

_____FOR OFFICE USE ONLY_____

If patient does not sign, please specify why patient chose not to sign the consent/acknowledgement of the notice of privacy.

_____

_____

All forms are for educational use only and do not constitute legal advice.
All forms are subject to change in the Federal Law and applicable State Laws.
Seek legal advice before use.