Heather F. Fleschler, D.D.S., F.A.G.D.

PERSONAL INFORMATION

Today's Date: _____

Name: _____
First Middle Last Preferred Name

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work):_____Ext: _____ (Cell):_____

Age: _____ Gender: __Male __Female Family Status: __Single __Married

Social Security#_____ Date of Birth _____ DL#_____

Email Address: _____

Employer: _____ Occupation (Student): _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Number(s):_____

RESPONSIBLE PARTY INFORMATION

Name: _____
First Middle Last Relationship to Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work):_____Ext: _____ (Cell):_____

Social Security#_____ Date of Birth _____ DL#_____

GETTING TO KNOW YOU

Whom may we thank for referring you to our practice? _____
__Friend __Relative __Dental Office __Internet __Work __Other: _____

Heather F. Fleschler, D.D.S., F.A.G.D.

DENTAL HISTORY

To provide you with the best possible care, please complete the dental & medical history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of last Dental Visit _____

Date of Last Cleaning _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

HIPPA regulations requires you (the patient) to contact your previous Dentist to release your x-rays

How often do you have dental examinations? _____

What is your daily oral homecare routine? _____

_____

Do you have any dental problems now? __Y __N

if yes, please describe _____

_____

Are any of your teeth sensitive to:

Hot or Cold? __Y __N

Sweets? __Y __N

Biting or chewing? __Y __N

Do you:

Notice any mouth odors or bad tastes? __Y __N

Frequently get cold sores, blisters or any other oral lesions? __Y __N

Do your gums bleed or hurt? __Y __N

Family history of gum disease? __Y __N

Tooth loss? __Y __N

Have you noticed any loose teeth? __Y __N

Have you noticed a change in bite? __Y __N

Does food get caught in your teeth? __Y __N

If yes, where?_____

Do you:

Clench or grind your teeth? __Y __N

Bite your lips or cheeks regularly? __Y __N

Hold foreign objects with your teeth? __Y __N

(i.e. pencils, pipe, pins, fingernails)

Breathe through mouth? (awake or asleep) __Y __N

Have tired jaws? __Y __N

Smoke/chew tobacco? __Y __N

Have you ever had:

Orthodontic treatment? __Y __N

Oral Surgery/Wisdom Teeth Removal? __Y __N

Periodontal Treatment/Deep Cleaning? __Y __N

Your teeth ground/bite adjusted? __Y __N

A bite plate or mouth guard? __Y __N

A serious injury to the mouth or head? __Y __N

If so, please describe, including cause:

_____

Have you noticed or experienced:

Clicking/Popping of the jaw? __Y __N

Pain? (joint, ear, side of face) __Y __N

Difficulty opening/closing mouth? __Y __N

Difficulty chewing on either side? __Y __N

Headaches/neck/back/shoulder? __Y __N

Numbness/tingling of fingertips? __Y __N

Tinnitus (ringing in ears)? __Y __N

Happy with your teeth's appearance? __Y __N

Do you feel nervous about treatment? __Y __N

if so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? __Y __N

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? __Y __N

If yes, please describe: _____

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MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? __Y __N

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you been hospitalized during the past two years? __Y __N

Please explain: _____

_____

3. Have you ever taken Fosamax, Boniva, Actonel, Reclast or any other medications containing bisphosphonates? __Y __N

4. Are you taking any prescription/non-prescription medications or supplements? __Y __N

If yes, please list name and dosage: _____

_____

5. Are you aware of having an allergic (or adverse) reaction to any of the following:

__Aspirin __Codeine __Latex __Local Anesthetic __Penicillin __Sulfa __ None

Other, please list: _____

6. Indicate which of the following you presently have or have ever had.

Lung Disease	__Y__N	HIV/AIDS	__Y __N
Asthma	__Y__N	Blood Transfusion	__Y __N
Seasonal Allergies	__Y__N	Hemophilia	__Y __N
Emphysema	__Y__N	Bruise Easily	__Y __N
Tuberculosis	__Y__N	Gastro-Intestinal disease	__Y __N
Heart (surgery, disease, attack)	__Y __N	Thyroid Disease	__Y __N
Angina/Chest Pain	__Y __N	Glaucoma	__Y __N
Congenital Heart Disease	__Y __N	Cancer	__Y __N
Heart Murmur	__Y __N	Radiation Therapy	__Y __N
High/Low Blood Pressure	__Y __N	Chemotherapy	__Y __N
Mitral Valve Prolapse	__Y __N	HPV	__Y __N
Artificial Heart Valve	__Y __N	Chicken Pox/Shingles	__Y __N
Heart Pacemaker	__Y __N	Sleep Apnea	__Y __N
Rheumatic Fever	__Y __N	CPAP	__Y __N
Arthritis/Rheumatism	__Y __N	Neurological Disease	__Y __N
Auto-Immune Disease	__Y __N	Stroke/TIA	__Y __N
Artificial Joints (hip/knee)	__Y __N	Epilepsy or Seizures	__Y __N
Diet (Special/Restriction)	__Y __N	Vertigo/Fainting/Dizzy Spells	__Y __N
Kidney Disease	__Y __N	Psychiatric treatment	__Y __N
Diabetes, Type I/II	__Y __N	Anxiety	__Y __N
Liver Disease	__Y __N	ADD/ADHD	__Y __N
Hepatitis A/B/C	__Y __N	Other, Please list:	_____

7. For Women: Pregnant? __Y __N Nursing? __Y __N Taking Birth Control Pills __Y __N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Heather F. Fleschler, D.D.S., F.A.G.D.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or assist with, aid in or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, other governmental or third party payer's, or any organizations contracting with any of the above or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You may have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Administrator to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices if effective immediately.

_____ _____

Patient Signature Date

Heather F. Fleschler, D.D.S., F.A.G.D.

DENTAL TREATMENT CONSENT FORM

1. I hereby authorize doctor or designated staff to take xrays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18%IPR) may be added to my account. If required, I also understand that a check of my credit history may be made.

FOR YOUR INFORMATION-PLEASE READ OFFICE POLICY

WE WOULD LIKE YOU TO BE INFORMED ABOUT OUR POLICIES. Please take a few moments to read and acknowledge this:

FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges, veneers, or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due payable when the initial impression is made.

AS A COURTESY TO YOU, Heather F. Fleschler, D.D.S., P.A., will, if necessary, accept 50% of this amount at the time of the impression. The balance must be at the time of permanent seating, or no more than 30 DAYS from date of impression, WHICHEVER COMES FIRST, unless prior arrangements have been made with our office administrator. We accept and file your insurance for payment; however, you must pay your portion at the time services are rendered.

PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PROPER FIT. If you fail to have your prosthetics seated within 60 days from the date of impression, and an additional impression must be made, you will be charged an additional amount of one-half of our current charge for such procedure.

WE OFFER YOU QUALITY DENTAL CARE and we want you to feel comfortable with all of our treatments and policies. Please feel most welcome to contact our office administrator for any questions you may have.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Relationship to Patient: _____

Heather F. Fleschler, D.D.S., F.A.G.D.

DENTAL INFORMATION & ACCEPTANCE FORM

1. Health Information

I agree to disclose all previous illnesses, medical and dental history, (e.g. gum disease) including all medications. Undisclosed medical information and current medication, allergies, or illnesses are risk factors. I agree to allow the use of my information only where it is necessary, for treatment or to process insurance claims.

2. Drugs, Latex, & Medication

I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is a potentially life-threatening condition that can interfere with normal breathing. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status, may be dangerous.

3. Needle Stick

If a staff member is inadvertently stuck with a needle used on me, I consent to have my blood drawn for analysis.

4. Fillings, Crowns, & Unanticipated Root Canals

It is possible that a tooth will need a root canal, even after a simple filling or crown is done.

5. Root Canal Possible Failure

Root canals can fail and may require additional treatment or require extraction (removal) of the tooth.

6. Porcelain Crowns, Veneers, Bonding, & Cosmetic Fillings

Once a crown, veneer, bonding, or filling is placed, I understand that color cannot be changed without a remake, and, that they can chip or break, just like real teeth. I have been informed and educated on how it is important to maintain a healthy balanced occlusion (bite). I know that this may be complicated due to stress, clenching, muscles, and teeth. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal guard or orthotic for protection.

7. Gum Treatment vs. "Just a Cleaning"

If I do not brush, floss or if I smoke, I can expect to have a deteriorating gum condition call Periodontal disease, which also affects the bone. I am aware that Periodontal disease requires more treatment than a simple cleaning.

8. Extractions & Surgery

I understand that all tooth extractions or dental surgeries carry risks. Some are minor, like a dry socket following an extraction. Some could be life threatening, such as post-surgical infection, bleeding or anaphylaxis.

9. Fee for Additional Care or Specialty Care

I understand that I may need treatment beyond what is originally planned (e.g. a crowned tooth may still need a root canal and may be referred to a specialist for additional care).

10. Limitation of Insurance Coverage

Often there are charges beyond what insurance will pay, (e.g. nitrous oxide/sedation, temporary dentures, teeth whitening, cosmetic treatment). Also, as a service to our patients, this office will file insurance claims on your behalf; however, I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover.

Heather F. Fleschler, D.D.S., F.A.G.D.

11. 24-Hour Notice of Cancellation

I agree to give 24-business hours notice of cancellation or I will pay the broken appointment fee of $95. I understand that leaving a message after the office is closed for the day (or weekend) before my appointment is NOT sufficient notice.

12. Requesting Record Transfer

Professional courtesies occur between dental offices. I understand that any previous records will be sent directly to this dental office only.

13. Hygiene Appointments

If I am more than 15 minutes late for my cleaning appointment, I will either accept what appointment time is left, or understand that my appointment will need to be rescheduled.

14. Appointment Times & Emergency Care

It is our office policy and philosophy to be readily available for any patient in discomfort, or in an emergency situation. This courtesy is extended to all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such times. We thank you, in advance, for your patience.

_____ _____

Patient/Guardian Signature Date

Heather F. Fleschler, D.D.S., F.A.G.D.

CONSENT FOR ANESTHETICS INCLUDING NITROUS OXIDE

This office is pleased to offer local anesthetic, as well as, conscious sedation such as nitrous oxide, commonly known as "laughing gas".

What is local anesthetic?

Local anesthetics have been used in medicine and dentistry for over 100 years. Previously called "Novocaine", local anesthetics, such as lidocaine, are used every day all over the world. They are injected via needles either next to the tooth or next to a nerve bundle to achieve the desired level of numbness.

What are the risks of local anesthetics?

1. Allergies-very few to the anesthetic agents are known. Some are allergic to the preservative inside the anesthetic. A few people are sensitive to an added ingredient called Epinephrine.
2. Sensitivity to Epinephrine-Epinephrine is commonly called adrenaline. It is added to constrict blood vessels so that the anesthesia lasts longer. However, Epinephrine causes the heart to beat faster. In some people that are sensitive to or have a weakened heart, this may be a risk factor.
3. The needle may hit a nerve causing temporary or permanent numbness.
4. Injecting the anesthetic into a vein may cause dizziness, palpitations, or a fainting spell.

What is Nitrous Oxide?

Nitrous Oxide is a safe, odorless gas that has a calming effect.

What are the risks of Nitrous Oxide?

1. Nitrous Oxide causes the veins to dilate (open) and may give the person a slight headache. This may be countered with a cup of coffee or soda, as caffeine closes the veins.
2. Some patients have experienced delirium or excitement. They see things in their mind and the images seem so real that they almost think it was real.
3. If the person receives too high a concentration of Nitrous Oxide, the feeling of the room spinning or loss of balance while sitting into the dental chair has been reported. Simply tell the dentist that you are not feeling the calming effect, but the opposite.
4. Unfortunately, not all people benefit from Nitrous Oxide. Some people have been known to fight the calming effects of Nitrous Oxide, and therefore, derive no benefit from inhaling it.

I understand there is a charge for the use of Nitrous Oxide. I have had the opportunity to ask questions. I understand the above and give consent.

_____ _____

Patient/Guardian Signature Date