***Lisa M Pedrick, DMD***

***Family and Cosmetic Dentistry***

***671 Exton Commons***

***Exton, PA 19341***

[***www.drpedrick.com***](http://www.drpedrick.com)

***610-594-9273***

Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Patient’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_

Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact method: ( ) Home ( ) Work ( ) Cell ( ) E-mail ( ) Text

Employer:­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single Married Widowed Divorced Other ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party for this account (if other than Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Address & Phone (if different from Patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for your referral? Another patient/friend Name of That Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [www.drpedrick.com](http://www.drpedrick.com)  Internet Search  Specialist Recommendation  Sleep Center/Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 American Academy of Facial Esthetics  Other ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance** *(if applicable)***:**

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Complete the following for the* ***Policy Holder*** *(if different from patient or responsible party):*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Lisa M Pedrick, DMD***

***Family and Cosmetic Dentistry***

Patient Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Name and Phone # of Treating Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you ever had any of the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies | Drug or Alcohol Abuse | Osteoporosis | Bacterial Endocarditis |
| Abnormal Bleeding | Emotional Problems | Panic Attacks/Anxiety | Heart Murmur |
| ADD/ADHD | Epilepsy or Seizures | Parkinson’s Disease | Irregular Heart Beat |
| ALS | Frequent Headaches | Radiation Treatment | High Blood Pressure |
| Anemia | Glaucoma/Eye Disorders | Respiratory Problems | High Cholesterol |
| Arthritis | Hearing Difficulties | Sinus Problems | Low Blood Pressure |
| Artificial Joint(s) | Hepatitis – Type: \_\_\_\_\_\_\_ | Sleep Apnea | Artificial Heart Valve(s) |
| Type and Year: \_\_\_\_\_\_\_\_\_ | HIV/AIDS | Stomach Problems/GERD | Congenital Heart Lesion |
| Asthma | Immunosuppressive | Stomach Ulcer/Colitis | Mitral Valve Prolapse |
| Blood Clot | Disorders | Stroke | Heart Attack |
| Cancer | Kidney Disease | Thyroid Problems | Year: \_\_\_\_\_\_\_\_\_\_\_ |
| Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Liver Disease or Jaundice | Tobacco Use | Angina/Chest Pain |
| Dementia or Alzheimer’s | Lyme Disease | Type & Amount: \_\_\_\_\_\_\_\_ | Pacemaker |
| Depression | Migraines | Venereal Disease/ STD | Heart Surgery |
| Diabetes | MS | Are You Pregnant? | Congestive Heart Failure |
| Dizziness or Fainting | Neurological Disorders | Due Date: \_\_\_\_\_\_\_\_\_ | Rheumatic Fever |

*Are you allergic to any of the following:*

|  |  |  |
| --- | --- | --- |
| Amoxicillin | Latex | Seasonal (dust, pollen, dander) |
| Aspirin | Local anesthetic (Novocaine) | Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Clindamycin | Penicillin | Other ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ |
| Codeine | Sulfa | Other ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Please list any prescription medications and over the counter supplements you are taking:*

­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been admitted to a hospital, had surgery or needed emergency care in the past two years? Yes No

*If yes, please explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other health concerns that need further discussion:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Lisa M Pedrick, DMD***

***Family and Cosmetic Dentistry***

Patient Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Dental History** (ages 1-12)**:**

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your child’s first visit to the dentist? Yes No

*If no:*

When was the last dentist visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist Name and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had dental x-rays? Yes No

Has your child had any problem with dental treatment in the past? Yes No

Has your child ever been hospitalized for dental treatment? Yes No

*Now or in the past, has your child ever had/used:*

|  |  |  |
| --- | --- | --- |
| Sensitive Teeth | Bad Breath | Dental Sealants |
| Speech difficulties | Cold Sores or any oral lesions | Clench or Grind Teeth |
| Injury to the mouth, head or teeth | Bite Nails | Snoring |
| Orthodontic treatment | Bite lips or cheek regularly | Prescription Fluoride Toothpaste |
| Mouth breathing | Dental or Gum surgery | Prescription Fluoride Rinses |
| Use sports mouth guard | Bottle at bedtime | Prescription Fluoride Tablets |
| Problems with the eruption or | Suck his/her thumb, fingers or | Family history of congenitally |
| losing of teeth | pacifier | missing teeth |

Who is responsible for brushing your child’s teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many times a day are they brushed? \_\_\_\_\_\_\_\_\_\_

Is flossing done routinely? Yes No

Is fluoride toothpaste used? Yes No

Currently drink from bottle? Yes No

Currently drink from "sippy" cup? Yes No

Is your water fluoridated? Yes No

Does your child have more than 3 sugary snacks or drinks per day? Yes No

Does your child drink any of the following on a regular basis (check all that apply)?

 Milk Juice Bottled Water Sports Drinks Soda  Tap Water

Is there anything else about having dental treatment that you would like us to know?Yes No

*If yes, please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my dentist, or any member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent’s/Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations:**

I authorize release of information to all of my insurance companies.

I agree to pay for services rendered at the time of treatment.

I agree that I am ultimately responsible for my bill.

I authorize Dr. Pedrick and her team to act as my agent in helping me to obtain payment from my Insurance companies.

I authorize payment directly to my doctor, Lisa M Pedrick, DMD.

I consent to all necessary dental procedures as deemed appropriate by Dr. Pedrick and her team.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photo Release:**

Your photos are part of your diagnostic and clinical record.

We make use of radiographs, photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

## Please Initial All Items Below That Apply:

\_\_\_ I authorize the use of my images where **my face** is identifiable

\_\_\_\_ I authorize the use of my images where **only my teeth** are identifiable

OR

\_\_\_\_Store images in my diagnostic record only

This authorization/release will remain in effect until cancelled. Any future cancellation will not affect the usability of images that have already been released. I have read and understand this form.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Privacy Practices – HIPAA Form**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

* Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a morecomplete description of the uses and disclosers of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices*  and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_