Lisa M Pedrick, DMD
Family and Cosmetic Dentistry
671 Exton Commons
Exton, PA 19341
www.drpedrick.com
drlisa@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 ☐ 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: _____

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

Are you allergic to any of the following:

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

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

_____

_____

_____

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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Patient Name: _____ Date: _____

Dental History (ages 13+):

What is the reason for your visit today? _____

Date of last Cleaning _____ Date of last Full Mouth Series of X-rays or PAN _____

Previous Dentist Name and Location _____

Now or in the past, have you ever had/used:

- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to chewing
- ☐ Bleeding or swollen gums
- ☐ Gum treatment or Surgery
- ☐ Food catching between teeth
- ☐ Canker Sores /Ulcers
- ☐ Cold Sores/Fever Blisters/ Herpes Virus
- ☐ Clench or Grind Teeth
- ☐ TMJ discomfort
- ☐ Jaw clicking or popping
- ☐ Orthodontic Treatment
- ☐ Wear a retainer
- ☐ Wear a night-guard
- ☐ Injury to Jaw, Mouth or Face
- ☐ Dry Mouth
- ☐ Sleep study performed
- ☐ Use CPAP
- ☐ Daytime sleepiness
- ☐ Tension Headaches
- ☐ Snoring
- ☐ Bite Nails
- ☐ Chew Ice
- ☐ Mouth breathing
- ☐ Whitening products
- ☐ Botox
- ☐ Dermal fillers
- ☐ Lip Augmentation
- ☐ Prescription Fluoride
- ☐ Family History of Oral Cancer
- ☐ Bad Breath

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What other dental aids do you use? (rinses, waterpik, electric toothbrush, etc.) _____

_____

Do you like the appearance of your smile?	Yes	No
Do you consider yourself a nervous dental patient?	Yes	No
Have you ever had an unpleasant dental experience?	Yes	No
Have you ever had problems with dental anesthesia or getting numb?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe:

_____

_____

*Are you interested in **information** on any of these topics:*

- ☐ Invisalign Orthodontics
- ☐ Teeth Whitening
- ☐ Replacing missing teeth
- ☐ Cosmetic Dentistry
- ☐ Fluoride Varnish
- ☐ Vizilite oral cancer screening
- ☐ Sleep Apnea Appliances
- ☐ Other: _____
- ☐ Facial Esthetics – Botox
- ☐ Facial Esthetics – Dermal Fillers
- ☐ Facial Esthetics – Lip Augmentation
- ☐ Other: _____

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 more complete 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: _____