Dan Ballenger DDS PA
Chris Houk DDS
12 Office Park Drive, Little Rock, AR 72211
501-227-7999
www.officeparkdental.com

NEW PATIENT INFORMATION
Welcome! We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. We look forward to getting to know you.

Whom may we thank for referring you? ____

ABOUT YOU
Name: ____ I prefer to be called_______________________ [ ] Male [ ] Female
[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: ____________________________

Home Address: ____
City___________________________ __________________State______ Zip______________

Home Phone: (____) _________________ Work: (____) _________________ ext. ___ Cell: (___) __________________
E-mail Address: ____

Employer: ____
Occupation: ____
Employer's Address: ____
City__________________________ State_______ Zip______________________

PERSON RESPONSIBLE FOR ACCOUNT
[ ] Same as above
Name: _______________________________________ Birth date:___/___/___ Relation: ___________________________
Billing Address: ____ City_______________ State______ Zip________
Home Phone: (____) _________________ Work: (____) _________________ ext. ___ Cell: (___) __________________
S.S. #: _______________________________
Employer: ____

EMERGENCY CONTACT INFORMATION
Name: ____
Employer: ____ Phone: (____) _______________________

DENTAL INSURANCE INFORMATION
Primary Insurance
Insurance Co. Name: _______________________________Phone: (____) _________ Group/Policy #: _______________
Insured's Name: ___________________________________Insured's Birth date: ___/___/___
Insured's Social Security #: _________________________ Insured's Employer: ___________________________________

Secondary Insurance
Insurance Co. Name: ______________________________ Phone: (____) _________ Group/Policy #: _______________
Insured's Name: __________________________________ Insured's Birth date: ___/___/___
Insured's Social Security #: _________________________ Insured's Employer: ___________________________________

MEDICAL HISTORY INFORMATION

Do you have or have ever had any of the following? Please check all that apply:

[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Angina/Chest Pain
[ ] Arthritis/Rheumatism
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Cortisone Medicine
[ ] Diabetes
[ ] Epilepsy or Seizures
[ ] Excessive Thirst
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disease/Attack
[ ] Heart Disorder (Congenital)*
[ ] Heart Infection*
[ ] Heart Murmur
[ ] Heart Pace Maker*
[ ] Heart Surgery*
[ ] Hemophilia
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorders
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Stroke
[ ] Stomach Ulcers
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice

*** This condition may require antibiotic premedication for certain dental procedures.**

Do you have any health problems that were not listed above or need further clarification?
Explain: ____

Are you now under the care of a physician?
Explain: ____
Name of Physician ____ Phone: _____________________
Have you been admitted to a hospital or needed emergency care during the past two years?
Explain: ____
Are you taking any medications?
List: ____
____
____
____

Allergies

Are you allergic to any medications or substances? ______
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Sulfa Other/Explain _____________________

Have you used tobacco? ______ If cigarettes, how many packs per day and for how many years?
Explain: ____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X ____ Date _____________________
Signature of patient, parent or guardian

DENTAL HEALTH QUESTIONNAIRE

Please help us better understand your dental health needs and goals by answering the following questions.

What is your main dental concern? ____

How long since your last dental exam?____

Did you have your teeth cleaned? ________________. Were x-rays taken of all your teeth? ___________

Do you go to the dentist every 6 months for cleanings? ____

Previous dentist ____

Please indicate if you presently have or have previously had any of the following:

Bad Breath	Yes [ ] No [ ]	Jaw pain	Yes [ ] No [ ]
Bleeding Gums	Yes [ ] No [ ]	Orthodontic Treatment	Yes [ ] No [ ]
Blisters on Lips	Yes [ ] No [ ]	Oral Cancer	Yes [ ] No [ ]
Dry Mouth	Yes [ ] No [ ]	Sensitivity to Hot	Yes [ ] No [ ]
Grinding Teeth	Yes [ ] No [ ]	Sensitivity to Cold	Yes [ ] No [ ]
Gums Swollen/Tender	Yes [ ] No [ ]	Periodontal Treatment	Yes [ ] No [ ]
Do you smoke?	Yes [ ] No [ ]		
Loose teeth	Yes [ ] No [ ]		

How often to you brush?______________________ How often do you floss? ____________________

Are you currently in pain?	Yes [ ] No [ ]
Do you require antibiotics before dental treatment?	Yes [ ] No [ ]
Do you feel nervous about having dental treatment?	Yes [ ] No [ ]
Are happy with your current smile?	Yes [ ] No [ ]

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

____

____

APPOINTMENT POLICY

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Patients that fail to give a 24-hour notice of appointment cancellation will be billed $75 for that appointment time.

FINANCIAL POLICY

We are happy to file your insurance for you, but we ask that you pay your estimated percentage at the time of your appointment. Patients are personally responsible for the payment of all dental services to be paid the day services are rendered. Patients that do not request a quotation of fees for services waive their right to later claim the fee exceeded the value of the services rendered. If delinquent, patients are responsible for all collection and attorney fees, which can be an additional 50% of patient account balance.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Ballenger and Dr. Houk. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Ballenger and Dr. Houk to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Ballenger and Dr. Houk.

Photography Release

I authorize Dr. Ballenger and Dr. Houk to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

Local Anesthesia Informed Consent

Local anesthesia may be used during dental treatment. This consent form is designed to make you aware of the risks involved with local anesthesia. The risks include, but are not limited to:

- Physiological effects such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions.
- Restricted mouth opening during recovery related to muscle soreness at the site of the injection. In rare instances this may require physical therapy.
- Prolonged numbness. This is especially concerning for children who may bite, chew or suck anesthetized areas of the mouth resulting in swollen lips, tongues, and cheeks. This type of trauma may also cause sores and ulcers.

- Injury to nerves that can result in pain, numbness, tingling or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for several weeks, months or, in rare instances, be permanent.
- Local anesthesia is administered with a very fine, small needle. In very rare circumstances these needles may break off and be lodged in soft tissue.

NITROUS OXIDE AND OXYGEN INFORMED CONSENT

Nitrous oxide/oxygen may be used during dental treatment. Nitrous oxide is perhaps the safest sedative used in dentistry. It is non-addictive. It is mild, easily taken and quickly eliminated from the body. The patient remains fully conscious and maintains all natural reflexes when breathing nitrous oxide/oxygen. This consent form is designed to make you aware of the risks involved with nitrous oxide/oxygen. The risks include, but are not limited to:
Occasional nausea or vomiting.

- Certain respiratory conditions that make breathing through the nose difficult may limit the effectiveness of nitrous oxide/oxygen.
- Certain medications can react negatively with nitrous oxide. Please inform the dentist of ALL medications being taken.
- If the patient is pregnant please notify the dentist and do not consent to the use of nitrous oxide.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I understand and agree to the **Local Anesthesia and Nitrous Oxide Consent.**
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me. [ ] Yes [ ] No

X ____ Date ________________________
Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.
I understand that I may ask any questions I may have regarding this notice.

Signature ____ Date _______________________