Aurora Dental Wellness
Dr. Lisa Y. Piña-Awosika
6515 Central Ave. Portage, IN 46368
(219)762.7080

Patient Information Form

Patient Name: _____ Date of Birth: _____ Sex: _____

Social Security #: _____ Phone (Cell): _____

Address: _____ Phone (Home): _____

_____ E-mail: _____

Did you serve in the military? _____ ☐ Active ☐ Retired Branch: _____

For Minor Patients:

Parent/Guardian's Name: _____ Relationship to Patient: _____

Primary Insurance Provider: _____ ID #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Employer: _____

Secondary Insurance Provider: _____ ID #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Employer: _____

1) Emergency Contact: _____ Phone: _____

Relationship: _____

2) Physician Contact: _____ Phone: _____

Address: _____

3) Preferred Pharmacy: _____ Phone: _____

Address: _____

How did you hear about us? /Referred by: _____

Signature: _____ **Today's Date**: _____

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Adult Patient Health History

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

NAME: _____ Birthdate: _____ Today's Date: _____

Please indicate if you have experienced any of the following:

- □ Previous Infective Endocarditis
- □ Congenital Heart Disease/Defects
- □ Heart Transplant: Year-_____
- □ Organ Transplant: Organ(s)/Year- _____
- □ Artificial Joint: Joint(s)/Year: _____
- □ Heart Disease
- □ Shortness of Breath
- □ Angina/Chest Pain
- □ Heart Murmur/Defect
- □ Artificial Heart Valve
- □ Congestive Heart Failure
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Rheumatic/Scarlet Fever
- □ Stent placed
- □ Past or Present Bone Treatment, Injection/Medication Name: _____

□ High Blood Pressure	□ Diabetes	□ High Cholesterol	□ Arthritis
□ Hepatitis	□ Tuberculosis	□ HIV/AIDS	□ STD
□ Cancer: Type: _____	□ Chemotherapy/Radiation	□ Radiation of Head/Neck	□ Allergies
□ Heart Attack: Year-_____	□ Blood Disorders	□ Gastrointestinal Condition	□ Asthma
□ Stroke: Year- _____	□ Seizures/Epilepsy	□ Fainting/Vertigo	□ Sleep Apnea
□ Blood Transfusion Year: _____	□ Abnormal Bleeding	□ Blood clots	□ Ulcers
□ Emphysema/COPD	□ Autoimmune Disease	□ Neurologic condition	□ Thyroid Disease
□ Heartburn/Reflux	□ Liver Condition	□ Kidney Condition	□ Osteoporosis
□ Anemia/Hemophilia	□ Alcoholism/Drug Use	□ Eating Disorder	□ ADD/ADHD
□ Migraines	□ Vision Condition	□ Hearing Impairment	□ Autism
□ Mental Health Disorder	□ Disability/Special Needs	□ Anxiety/Depression	

Women: □ Pregnant Expected delivery date: _____ □ Nursing

Do you have any disease, condition, or concerns not listed above? □ No □ Yes
If yes, please describe. _____

Have you been ill, hospitalized or had any surgeries? □ No □ Yes
If yes, please describe. _____

Current Medications (Over the Counter/Prescription/Vitamin):
_____
_____

Allergies (Medication/Latex/Food/Other):
_____
_____

Check any of the following:

Alcohol use**:**	□ No	□ Yes-How often? _____	□ Previous	Do you want to quit? Y / N
Tobacco Cigarettes:	□ No	□ Yes-How often? _____	□ Previous	Do you want to quit? Y / N
Tobacco Chew/Snuff	□ No	□ Yes-How often? _____	□ Previous	Do you want to quit? Y / N
Vape/E-cigarette:	□ No	□ Yes-How often? _____	□ Previous	Do you want to quit? Y / N
Recreational Drugs:	□ No	□ Yes-Type-_____	□ Previous	Do you want to quit? Y / N

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/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.

Patient Signature (or Guardian): _____**Date: _____**

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Adult Patient Dental Health History

Primary reason for this dental appointment: _____

Date of your last dental visit: _____ Date of your last dental cleaning: _____
Have you had cavities? □ Yes □ No Have you been told you have gum disease? □ Yes □ No

Do you have any dental concerns? _____
□ Sensitivity □ Tooth Pain □ Broken Teeth or fillings □ Bleeding, swollen gums
□ Jaw joint pain □ Dry Mouth □ Headaches/earaches/neck pain □ Loose/tipped/shifting teeth
□ Missing teeth □ Dental Anxiety □ Snoring/Difficulty Sleeping
□ Other: _____

Recent or previous trauma to teeth/mouth/face?
If yes please explain: _____

Dental Habits: Check all that apply
□ Grinding/clenching teeth □ Cheek biting □ Lip sucking/biting □ Nail biting □ Other: _____

Dental Care Routine:
□ Brush-How often? _____ □ Floss-How often? _____ □ Mouthwash-How often? _____
Fluoride toothpaste? □Yes □ No □ Water flosser □ Other: _____

Diet:
Water? □ Rarely/Never □ Well □ Tap □ Bottled □ Fruit Infused/Sweetened
Sugary Beverages? □ Rarely/Never □ Soda/Juice □ Energy Drinks □ Sweetened Coffee/Tea □ Other: _____
Sweets? □ Rarely/Never □ Candy □ Desserts/Pastries □ Breads/Starches □ Other: _____

Health:
Have you ever been advised to take an antibiotic before dental appointments? □ Yes □ No
Are you currently taking a blood thinner medication? □ Yes □ No
Have you ever been advised to stop a blood thinner before dental appointments? □ Yes □ No
Have you ever had artificial heart valve, valve replacement, or repair? □ Yes □ No
Have you ever had any joints replaced? □ Yes □ No If yes, when and which joints? _____
Have you ever taken a medication for your bones? □ Yes □ No
Have you ever had radiation therapy to the head and neck area? □ Yes □ No
Do you take a steroid daily or receive corticosteroid injections? □ Yes □ No
Have you ever had any complications to previous dental treatment? □ Yes □ No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/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.

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Printed Name: _____ Birthdate: _____ Today's Date: _____

Patient Health Authorization

- ✓ I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
- ✓ I understand that over time information including but not limited to my health and insurance may change and it is my responsibility to update these changes with the office and will need to complete an update form yearly in the best interest of my care.
- ✓ I authorize the diagnosis of my dental health by means of examination, radiographs, study models, photographs, or other diagnostic aids deemed appropriate by my provider.
- ✓ I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself any of my dependent(s) to third-party carriers, payors, and/or healthcare practitioners as deemed appropriate by my provider.

I have read and understand the policy and how it applies to me.

Signature: _____

Financial Policy

- ✓ I authorize the payment from insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.
- ✓ I understand that I am financially responsible for any outstanding balance for service provided that are not fully covered by insurance, and I may be billed for the remaining balance. I understand that Aurora Dental Wellness submitting my treatment to insurance is a courtesy and not a requirement. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependent(s) if any, with such responsibility including collection costs and attorney fees should my account become delinquent.

I have read and understand the policy and how it applies to me.

Signature: _____

No Show/Cancellation Policy

We at Aurora Dental Wellness understand that there are instances when appointments need to be rescheduled. However, time with the dental provider has been set aside specifically for you. We request that you notify our office as soon as possible if you need to make changes to your appointment including rescheduling and cancellations. You must cancel your appointment within a minimum of 24 hours otherwise, a charge will be assessed to your account. The fee is $25 per scheduled appointment. You will be billed personally, as insurance does not cover fees for missed appointments.

I have read and understand the policy and how it applies to me.

Signature: _____

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Acknowledgement of Receipt/Review of Notice of Privacy Practices-HIPAA Form

I have received/reviewed a copy of this office's Notice of Privacy Practices to review and retain.

*HIPAA policy on next page. Please inform the receptionist if you would like to have a copy to keep.

Printed Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices, but acknowledgement could not be obtained.

_____ Individual refused to sign. Explain: _____

Personal Health Disclosure Form

I authorize Aurora Dental Wellness to use or to disclose the health information of,

(Patient Name): _____ to the receiving party listed below. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand I may have a copy of this authorization.

Receiving Party: _____

The health information to be used or disclosed is limited to the following: (You may note dates, procedures, or other information.) _____

_____

I allow this form to be valid for: 1 year

***Any changes to this authorization must be provided in writing to ADW.**

Printed Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____