

Milestone, Inc.
Milestone Dental Clinic
Patient History

Patient Information

Full Legal Name: _____ D.O.B. _____
Patient Address: _____ Phone: _____
Social Security #: _____ Public Aid ID#: _____

Private Dental Insurance see below

PLEASE PROVIDE COPY OF DENTAL INSURANCE CARD AND/OR MEDICAID CARD AT THE TIME OF EACH APPT.

Legal Guardian/Guarantor

Name: _____ Home Phone: _____
Address: _____ Bus. Phone: _____
Relationship to Patient: _____
Email: _____ Fax: _____

Care Agency: Please Indicate: _____ Direct care _____ Indirect care

Name: _____ Phone: _____
Address: _____ Fax: _____
Case Manager: _____ Email: _____

Primary Physician

Name: _____ Phone: _____
Address: _____ Fax: _____
Date of last exam: _____

Private Dental Insurance- (if none skip)

PPO or HMO: _____
Name of Subscriber and mailing address for claims _____

Subscriber ID **and** SSN _____
Date of birth of subscriber: _____
Group Number: _____
Phone Number for Benefit Verification: _____
When possible please provide copy (front & back) of dental insurance card(s)

Please return completed forms to
Milestone Dental Clinic
275 N. Phelps Ave.
Rockford, IL 61108
(815) 484-8678
(815) 484-8680 Fax

**PLEASE PROVIDE A COPY OF THE PATIENT'S MOST RECENT YEARLY PHYSICAL EXAM
ALWAYS PROVIDE CURRENT MEDICATION LIST AT EACH APPOINTMENT**

PATIENT PROFILE

Patient Name: _____

Height: _____

Weight: _____

Hearing Impaired: Yes or No

Visually Impaired: Yes or No

Sex Male or Female

Wheelchair: Yes or No

Does patient have meaningful speech? **Yes or No**

Describe degree and nature of disability and functional level of patient. (Example: mental age, care needs, disability cause, and diagnosis)

List present medications and their doses and frequencies. (DO NOT LEAVE BLANK)

Please note, only sedation orders written by Milestone Dentists are to be administered to patients. Any pre-existing sedation orders need to be discontinued prior to the start of treatment here.

If patient is allergic to any medications, local anesthesia, foods, latex etc. Please list what they are allergic to and the reaction.

Has patient been hospitalized in the last 5 years? **Yes or No** If yes, for what and when? _____

Describe any serious trouble the patient has had with previous dental treatment (including behavioral, aggression, sedation, bleeding, vomiting, biting):

Suggestions for positive reinforcers: (i.e.: stickers, coins, etc.)

Date of last dental treatment? _____ Who was the dentist? _____

What was the treatment? _____

Reason for leaving that dental office? _____

Does the patient have any oral habits? (Finger sucking, hand biting, chewing on objects, grinding of teeth, chewing on clothes, eating of non-edibles, smoking, biting, etc.)

Name: _____

Who is responsible for brushing the patient's teeth? _____
How many times a day? _____

Any recent weight gain or loss? **Yes or No**
Is the patient on a special diet? **Yes or No**
What kind? _____

Does the patient have a feeding tube? **Yes or No**
Does the patient require assistance with feeding? **Yes or No**

Does the patient gag or vomit easily? **Yes or No**
Explain: _____

Does the patient smoke or use tobacco products? **Yes or No** How many years? _____

Does the patient wear any removable appliances or dentures? **Yes or No**
What? _____ Age of the appliance? _____

Circle any of the following, which the patient has or has had in the past?

- | | | | |
|----|-------------------------------------|----|------------------------------------------|
| 1 | Mental retardation | 22 | Mitral Valve Prolapse |
| 2 | Autism | 23 | Heart surgery |
| 3 | Seizures | 24 | Heart Dysfunction- Please give details |
| | When was the last seizure? _____ | 25 | Pacemaker |
| | How long did it last? _____ | 26 | High/low Blood Pressure |
| | What type of seizure? _____ | 27 | Shunt for fluid on the Brain |
| | Home many per day? _____ | | Type VA or VP |
| 4 | Down Syndrome | 28 | Oral Sores (including herpes) |
| 5 | Cerebral Palsy | 29 | Venereal disease |
| 6 | Traumatic Brain Injury | 30 | AIDS/HIV + |
| | When? Cause? _____ | 31 | Blood Disorders (Type?) _____ |
| 7 | Stroke/CVA | 32 | Steroid Medications |
| 8 | Liver disease | 33 | Pnuemonia |
| 9 | Hepatitis | 34 | Depression |
| 10 | Kidney disease | 35 | Schizophrenia |
| 11 | Diabetes | 36 | Post Traumatic Stress Disorder |
| 12 | Breathing problems | 37 | Intermittent Explosive Disorder |
| 13 | Asthma | 38 | Attention Deficit Hyperactivity Disorder |
| | How often do you use inhaler? _____ | 39 | Tourette's Syndrome |
| 14 | Thyroid disease | 40 | Cancer (Chemo? Radiation?) |
| 15 | Tuberculosis | 41 | Physical/sexual abuse |
| 16 | Arthritis | 42 | Substance abuse |
| 17 | Limited joint movement | 43 | MRSA+ |
| | Artificial joints (i.e. knee, hip) | 44 | Stomach ulcers |
| 18 | Date of placement _____ | 45 | Gastro-esophageal reflux disease |
| 19 | Heart Murmur | | |
| 20 | Rheumatic Fever | | |
| 21 | Artificial Heart Valve | | |

Please add any other information concerning this patient's medical or mental health, which we should know.

Signature- Relationship to patient

MILESTONE, INC.
Milestone Dental Clinic

Consent for Routine Dental Treatment

PATIENT NAME: _____ **D.O.B.** _____

Consent is hereby provided for Milestone Dental Clinic and its professional staff, to provide routine clinical dental treatment for the above named patient. The scope of routine care may be limited by availability of resources provided by the State of Illinois, and the ability of staff and patient to proceed in a compatible fashion toward acceptable treatment.

It is understood that Milestone Dental Clinic will be provided with the patient's complete health history information and that all of the patient's protected health care information will be safeguarded according to the clinic's "Notice of Privacy Practices" under HIPAA and applicable Illinois State Laws.

I hereby authorize the Milestone Dental Clinic and Staff to perform routine dental treatment. I understand that any health care treatment, including dental treatment, can on occasion result in untoward and unforeseen consequences. I acknowledge that I was made aware of the risks of dental procedures involved and was given the opportunity to ask questions. I hereby consent to the procedures to be done and authorize the appropriate health care professionals at the Milestone Dental Clinic to use their professional judgment in addressing and implementing additional or different procedures deemed necessary at the time.

I consent to the use of any local anesthetic deemed necessary and advisable, by the treating dentist, to successfully complete routine treatment. This local anesthetic will be applied by and supervised by the treating dentist.

I certify that I have read, or had read to me, this document and have had an opportunity to read about risks, benefits and alternatives for routine dental care, (on attached information sheet) that all blanks were filled in before I signed, and that I did understand the nature of this paper at the time I signed. I understand this consent is provided voluntarily and I intend to be legally bound by this.

Valid no more than two years after date signed.

SIGNED: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: (Circle one) Parent Guardian Self

FACILITY NAME (if applicable): _____

**Return to: Milestone Dental Clinic, 275 N. Phelps Ave., Rockford, IL 61108
(815) 484-8678**

MILESTONE, INC.
Milestone Dental Clinic
Medical Immobilization Consent

Patient Name: _____ **D.O.B.** _____

For those individuals who require medical immobilization/ protective stabilization for dental appointments, I hereby authorize Milestone Dental Clinic and whomever they may designate as their professional staff or assistants, to use medical immobilization and/or preoperative sedation in the course of providing routine dental treatment for the above named individual. I have read the information sheet attached describing the reasons why this immobilization might be necessary, the expected benefits, possible alternatives and foreseeable risks of this approach.

I understand that, if necessary, the following types of immobilization may be used:

Staff employing supportive measures

Arm and/or leg bands

Head stabilization

Positioning Devices (i.e. foam wedges, towels, blankets, pillows)

Mouth prop (device to keep mouth open)

Rainbow Wrap

Chemical restraint (Drugs administered orally or intravenously)

I understand the risks and the expected benefits of dental treatment and the possible consequences of the lack of dental care for the above named patient and accept responsibility for such consequences.

Valid no more than two years after date signed. (Unless withdrawn by guardian)

Signed: _____ **Date:** _____

Relationship: (Circle one) Parent Guardian Self

Witness: _____

Self Guardians ONLY Check off one of the following:

I refuse any immobilization

I accept immobilization if needed to complete dental treatment. I will be explained it's use with a witness present.

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

Milestone Dental Clinic
275 N. Phelps Avenue
Rockford, IL 61108
815-484-8678

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 disclosures 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 do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other