Welcome to our practice!

COMPTON DENTAL

Family and Cosmetic Dentistry

ALEX COMPTON, DMD

Please take a few minutes to answer the following questions so we can better assist you with your needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex: ○ M ○ F ☐ Minor ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Bus. Phone _____

Business Address _____ Occupation _____

How did you hear about us? _____

In Case of Emergency Please Contact _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Bus. Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

SECONDARY DENTAL INSURANCE

Insured Name _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Bus. Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

Please Complete Reverse Side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please Check All That Apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips/Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head & Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment	○	○
2. Have you ever had any serious illness or operations?	○	○
3. Are you currently taking any medications?	○	○
If so, please describe _____		
4. Do you smoke?	○	○
5. Do you use alcohol, cocaine or other drugs?	○	○
6. Do you wear contact lenses?	○	○

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. Novocaine)	○	○
Penicillin or other Antibiotics	○	○
Sulfa Drugs	○	○
Barbiturates (Sleeping Pills)	○	○
Sedatives	○	○
Latex	○	○
Iodine	○	○
Aspirin	○	○
Other	○	○

8. (Women only) Are You:

	Yes	No
Pregnant?	○	○
Nursing?	○	○
Taking Birth Control	○	○

PLEASE CHECK ALL THAT APPLY

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis/Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding Abdominally, with Extractions or Surgery ☐	Hepatitis - Type ____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Latex Sensitivity ☐	Tonsillitis ☐
Circulatory Problems ☐	Kidney Disease ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or Growth on Head/Neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough - persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

Signature of Responsible Party _____ Date _____

Email Form **CLICK HERE TO SEND TO INFO@COMPTON-DENTAL.COM**

COMPTON DENTAL

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because found while working on teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.

5. FILLINGS AND RESTORATIONS

I understand that care must be exercised in chewing on the new filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling.

6. REMOVAL OF TEETH (EXTRACTION)

An alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be

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necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for a period of time or a fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. CROWNS, BRIDGES, VENEERS, AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or veneer (including shape, fit, size, placement, and color) will be done before cementation. It explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The potential problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after. The cost of this procedure is not the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally posts are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including nonsurgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.
This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

Patient Signature and Date: _____

Print Patient Name: _____

Parent/Legal Guardian Name and Date: _____

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Patient Photo Release Form

I _____, hereby authorize Compton Dental Family and Cosmetic Dentistry, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.)

I further understand that if the photographs, slides, and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I am signing this form for my child/minor whom I am legally responsible for, I also give authorization to Compton Dental to use my child/minor's photograph, slide, or video in the same situations as stated above. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____ I do not mind if my photographs are used in any of the above stated situations

_____ I only agree to have my teeth shown without any identifying features.

_____ Decline all

Reschedule Policy

Thank you for choosing Compton Dental Family and Cosmetic Dentistry. Trying to accommodate every patient's individual needs and work schedule can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our patient's wait time is as minimal as possible.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed, canceled, or rescheduled, that time is permanently lost.

We ask when you schedule an appointment that you keep your commitment.

In order to provide the highest quality services to our patients, we have enforced a Reschedule Policy.

Please review the following agreement and sign the appropriate line, indicating that you understand this policy.

As a patient or guardian for a patient receiving services from Compton Dental Family and Cosmetic Dentistry, I understand the following:

1. **I am responsible for canceling appointments within 48 hours prior to my scheduled appointment time.**
2. **Should I fail to attend my appointment, reschedule or cancel within a 48-hour period, I will be charged a $50.00 fee.**
3. **Compton Dental Family and Cosmetic Dentistry reserves the right to release any patient due to excessive tardiness, missed or rescheduled appointments.**

Patient Name_____

Parent/Guardian Signature _____ **Date** _____

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HIPAA Consent

The Health Information Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by
HIPAA, we have prepared and explanation of how we are required to maintain the privacy of health information and how we may use and disclose your health information. If you would like a copy of the HIPAA Privacy Policy, please notify someone at the front desk to assist you.
I have read and understand the policy of Dr. Compton's HIPAA Consent

Insurance Policy

As a courtesy to our patients, we do file your insurance for you. However, **it must be stressed that your insurance is a contract between you, your employer and the insurance company. We are not a third party to this contract unless you are a member of a PPO group in which Dr. Compton participates**. In such cases, we will handle your claims according to our agreement with the insurance company, if one exists. While we will do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc. Not all services are covered by your plan and every plan is different. **If you have questions about your benefits, please call your insurance company.** It would be helpful for you to know your anniversary date, annual deductible and annual maximum, coverage percentages, and any wait periods.

You are expected to pay the estimated portion of your fee before being seated at the time services are rendered. However, this is only an estimate. If there is any difference after your insurance pays, we will send you a statement.

You are responsible for the timely payment of your account. If your insurance company has not paid your claim in full within 60 days, the balance and all follow-up with the insurance company becomes your responsibility. As a reminder, after 90 days we assign all accounts to a collection agency for processing.

I hereby authorize payment of dental benefits otherwise payable to me to be paid directly to Dr. Alex K Compton, D.M.D furthermore; I realize that I am ultimately responsible for payment.

MAJOR RESTORATIVE WARRANTY

Crowns, bridges and partials done at Compton Dental have a five-year warranty from PREP date, provided they are seated **within two months of impression date**. If not seated within **eight** weeks of IMPRESSION date, there will be a **$300 charge per unit** to re-prep each tooth. **I also understand that I must come in for routine continuing care (CLEANING) visits at least every six months or what my dental health care professional deems necessary for appropriate long-term maintenance of my oral health and maintenance of any major restorative procedure performed by Compton Dental**. It is imperative that the patient remain in a temporary unit until the seat date. If for any reason the temporary should come off, the patient must contact our office as soon as possible to have it recemented in a timely manner.
Failure to comply will result in LOSS OF WARRANTY.

SIGNATURE:_____DATE:_____