THE FACIAL PAIN CENTER

Patient Bill of Rights:

- You have the right to be treated with respect, consideration, and dignity by doctors and team members in this dental practice.
- You have the right to privacy as it relates to your patient information and dental care. Patients shall be assured confidential handling of their dental and financial records and may approve or refuse their release, except when required by law.
- You have the right, to the degree known, to receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- You have the right to refuse participation in scientific research.
- You have the right to change dentists within the practice or transfer to another The Facial Pain Center location.
- You have the right to be informed of the wide range of dental services available to you.
- You have the right to after-hours and emergency care should the need arise.
- You have the right to be informed of the payment/financial policy.
- You have the right to express grievances or make suggestions by submitting them in writing to:

The Facial Pain Center
2200 County Road C West, Suite 2210
Roseville, MN 55113

Patient Rights and Responsibilities:

Patients have the responsibility to:

- Be considerate of the privacy and rights of other patients and be respectful of the doctors and team members.
- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider for you and/or your children, and participate in his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Notify The Facial Pain Center at least 24 hours in advance if unable to keep scheduled appointment(s).
- Understand and ask questions regarding treatment.
- Continue care with recommended appointments and follow through with after care instructions.

If you have questions, please call your dental practice.

Thank you for choosing The Facial Pain Center.

THE FACIAL PAIN CENTER

Patient Personal Information

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ Student _____SSN _____
Email _____ School Name _____
_____ How did you hear about our practice? _____
Is patient responsible for paying bills? ☐ Yes ☐ No

Person responsible/guarantor for paying bills

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ SSN _____
Email _____

Dental Insurance

Do you have **Primary** Dental Insurance? ☐ Yes ☐ No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____

Do you have **Secondary** Dental Insurance? ☐ Yes ☐ No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____

Name: _____ DOB: _____

THE FACIAL PAIN CENTER

Medical Alerts

Do You Have the Following:

- ☐ Amoxicillin Allergy
- ☐ Aspirin or Ibuprofen Allergy
- ☐ Augmentin Allergy
- ☐ Epinephrine Sensitivity Allergy
- ☐ Erythromycin Allergy
- ☐ Clindamycin Allergy
- ☐ Codeine / Other Pain Killers Allergy
- ☐ Iodine Allergy
- ☐ Latex or Rubber Product Allergy
- ☐ Local Anesthetics Allergy
- ☐ Metals Allergy
- ☐ Penicillin Allergy
- ☐ Sedatives or Barbiturates Allergy
- ☐ Sulfa Drugs Allergy
- ☐ Other Allergy (list on Medical Questionnaire)

Are You Using the Following

- ☐ Antibiotics
- ☐ Anticoagulants/Blood Thinners
- ☐ Aspirin
- ☐ Cortisone/Prednisone
- ☐ High Blood Pressure Medication
- ☐ Insulin
- ☐ Motrin/Aleve/ Ibuprofen
- ☐ Oral Anti-Diabetic
- ☐ Nitroglycerin

Currently Taking or Ever Taken

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Prolia
- ☐ Reclast
- ☐ Zometa
- ☐ Other Bisphosphonates

Check, if applicable

- ☐ Premedication Needed
- ☐ Alcohol/Drug Abuse
- ☐ Cancer/Tumor Growth
- ☐ Chemotherapy/Radiation
- ☐ Communication Issue
- ☐ Development Delay
- ☐ Learning Problems
- ☐ Organ Transplant
- ☐ Sensory Integration Disorder
- ☐ Wheel Chair

EYE, EAR, NOSE, THROAT PROBLEMS

- ☐ Canker Sores
- ☐ Cold Sores (Herpes)
- ☐ Ear Aches (Otitis)
- ☐ Frequently Dry Mouth/Sjogren
- ☐ Glaucoma
- ☐ Large Tonsils or Adenoids
- ☐ Hay Fever/Seasonal Allergies
- ☐ Hearing Impaired
- ☐ Sinus Trouble
- ☐ Vision Loss

HEART PROBLEMS

- ☐ Mitral Valve Prolapse
- ☐ Angina
- ☐ Chest Pain
- ☐ Congenital Heart Defects
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Damage
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Rheumatic Fever

LUNG PROBLEMS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Reactive Airway Disease
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

VASCULAR/BLOOD PROBLEMS

- ☐ Anemia
- ☐ Leukemia
- ☐ Excessive, Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Bypass Surgery

GASTROINTESTINAL PROBLEMS

- ☐ Acid Reflux
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatial Hernia
- ☐ Intestinal Bleeding
- ☐ Ulcers

GENITOURINARY PROBLEMS

- ☐ Dialysis
- ☐ Kidney Disease/Failure
- ☐ Urinary Tract Infections

MUSCLE/BONE/SKIN PROBLEMS

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ History of Skin Problems
- ☐ Joint Problems
- ☐ Muscle Problems
- ☐ Neck Problems
- ☐ Osteoporosis

NERVOUS SYSTEM PROBLEMS

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anorexia / Bulimia
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disease
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Depression
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Injury to Head
- ☐ Migraines
- ☐ Muscular Dystrophy
- ☐ Numb Areas
- ☐ Paralysis
- ☐ Parkinsons Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Other Psychiatric Condition

ENDOCRINE PROBLEMS

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Low Blood Sugar
- ☐ Thyroid Problems

IMMUNE SYSTEM PROBLEMS

- ☐ AIDS/HIV
- ☐ Lupus
- ☐ Rheumatoid Arthritis

OTHER PROBLEMS

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Measles, Mumps, Chickenpox
- ☐ Other Medical Condition

Name: _____ DOB: _____

THE FACIAL PAIN CENTER

Dental Questionnaire

1. Name, Address & Phone of Previous/Referring dentist: _____
2. When did you last visit a dentist? _____
3. What was done at that time? _____
4. Why did you leave that dentist? _____
5. Date of your last cleaning _____
6. Date of your last exam _____
7. Date of your last full series of x-rays _____
8. Date of last cavity detection (bitewing) x-rays _____
9. Has any dental treatment been recommended to you that you have not done? ☐ Yes; Describe: _____ ☐ No
10. Are you aware of any dental problems? ☐ Yes; Describe: _____ ☐ No
11. What do you feel is the present condition of your mouth? _____
12. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
13. Have you ever been treated for gum disease? ☐ Yes; what was done:_____ ☐ No
14. Are your teeth sensitive to any of the following: ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure ☐ Nothing
15. Are you happy with the appearance of your smile? ☐ Yes ☐ No; Explain: _____
16. Are you concerned with bad breath (malodor)? ☐ Yes ☐ No
17. Are you concerned with snoring or sleep apnea? ☐ Yes ☐ No
18. Are you concerned with grinding your teeth (bruxism)? ☐ Yes ☐ No
19. Are you aware of possible TMJ problems (does your jaw make noise or lock up)? ☐ Yes ☐ No
20. Have you had any injury to your teeth, jaw or face? ☐ Yes; Describe:_____ ☐ No
21. Do you have dental anxiety? ☐ Yes ☐ No
22. If yes, is there anything you are aware of that helps alleviate the anxiety? _____

Additional Comments

Is there anything else that would be helpful for your dentist to know? ☐ Yes ☐ No

Name: _____ DOB: _____

THE FACIAL PAIN CENTER

Medical Questionnaire

1. Emergency Contact Name and Phone #: _____
2. Primary Physician Name, Address and Phone: _____
3. Referring Physician Name, Address and Phone: _____
4. Are you in good health? ☐ Yes ☐ No
5. When was your last physical examination? _____
6. Are you currently under care of a Physician? ☐ Yes; Condition: ☐ No
7. Have you had any serious illness, operation, accident or been hospitalized? ☐ Yes; Describe: ☐ No
8. Has there been any change in your general health in the past year? ☐ Yes; Describe: ☐ No
9. Are you currently taking any medication other than listed earlier, including OTC, vitamins or herbal remedies? ☐ Yes; Please provide a list. ☐ No
10. Have you had previous problems with general or local anesthesia? ☐ Yes; Describe: ☐ No
11. Do you have any allergies besides what was listed in the Patient Medical Information Section? ☐ Yes; Describe: ☐ No

Women Only

12. Are you pregnant or is there a chance you may be pregnant? ☐ Yes- Due Date_____ ☐ No
13. Are you currently nursing? ☐ Yes ☐ No

Family/Personal/Social History

14. Mother Healthy? ☐ Yes ☐ No; Explain:_____
15. Father Healthy? ☐ Yes ☐ No; Explain: _____
16. Do you now or have you ever used:

Tobacco/Chew/e-cigarettes	☐ No	☐ Yes	Frequency _____	Number of years _____	Quit Date_____
Alcohol	☐ No	☐ Yes	Frequency _____	Last Drink _____	Quit Date _____
Recreational/Street Drugs	☐ No	☐ Yes	Frequency _____	Number of Years _____	Quit Date _____

Additional Comments

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date

INFORMATION UPDATED

_____ _____

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date

THE FACIAL PAIN CENTER

Patient Medication Form

Patient Name		ID #		DOB		Gender	__ M __ F

Medication & Dosage	Indication for Use	Start Date

Updated Form – Admin Only	
Date	**Name**

For Admin Use Only – Entered into QDW		
Date		Name