TODD W. FRUIT, D.M.D.
Neuromuscular • Cosmetic • Restorative • Preventative

Full legal name: _____ D.O.B.: _____

Address:_____Zip:_____

Email:_____**Cell Phone_____Home Phone_____**

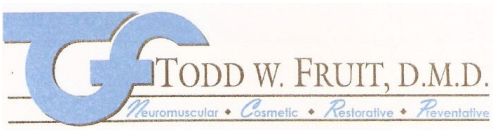
How did you find out about our office?_____

Medical History: Please check ' Yes ' or ' No '

Cardiovascular Disease		**Blood Disorders**			
Heart Attack or Heart Disease	Yes ○ No ●	Anemia	Yes ○ No ○	Ulcers	Yes ○ No ○
Stroke	Yes ○ No ●	Hemophilia	Yes ○ No ○	Reflux	Yes ○ No ○
Heart Surgery	Yes ○ No ●	Leukemia/ Lymphoma	Yes ○ No ○	Glaucoma	Yes ○ No ○
Pacemaker/Artificial Valves	Yes ○ No ●	High Blood Pressure	Yes ○ No ○	Alcohol Abuse	Yes ○ No ○
Heart Murmur	Yes ○ No ●	Low Blood Pressure	Yes ○ No ○	Drug Abuse	Yes ○ No ○
Mitral Valve Prolapse	Yes ○ No ●	HIV/AIDS/ARC	Yes ○ No ○	Cancer	Yes ○ No ○
Chest Pains	Yes ○ No ●	Venereal Disease	Yes ○ No ○	Radiation	Yes ○ No ○
Congenital Heart Defect	Yes ○ No ●	Hepatitis	Yes ○ No ○	Chemo Therapy	Yes ○ No ○
Rheumatic Fever	Yes ○ No ●	Diabetes	Yes ○ No ○	Cosmetic Surgery	Yes ○ No ○
Scarlet Fever	Yes ○ No ●	Hypoglycemia	Yes ○ No ○	Shingles	Yes ○ No ○
Pulmonary Disease		Sickle Cell Anemia	Yes ○ No ○	Fainting	Yes ○ No ●
Difficulty Breathing	Yes ○ No ●	**Other Health Concerns**		Seizures	Yes ○ No ○
Tuberculosis	Yes ○ No ○	Hypothyroid	Yes ○ No ○	Epilepsy	Yes ○ No ○
Emphysema	Yes ○ No ○	Hyperthyroid	Yes ○ No ○	Headaches	Yes ○ No ○
Sinusitis/Allergies	Yes ○ No ○	Kidney Disease	Yes ○ No ○	Osteoporosis Drugs	Yes ○ No ○
Asthma/Bronchitis	Yes ○ No ○	Liver Disease	Yes ○ No ○		
COPD	Yes ○ No ○	Joint Replacement	Yes ○ No ○		
Apnea	Yes ○ No ○	Organ Transplant	Yes ○ No ○		

Snoring

Do you use a C-Pap?	Yes ○ No ○	Back or Neck Injuries	Yes ○ No ○	Arthritis	Yes ○ No ○



Do you have any allergies? Latex ☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Sulfa ☐ Codeine ☐

Rubbing Alcohol? ☐ Dental Anesthetics: Lidocaine, Marcaine, etc. ☐

Food/Other_____

Do you bleed excessively when cut? Yes ◉ No ○

Are you pregnant? Yes ◉ No ○

Due Date_____

Do you use tobacco products such as cigarettes, cigars or chewing tobacco? Yes ○ No ○

How frequently? Daily ○ Weekly ○ Monthly ○

Does a cardiologist/orthopedic doctor require you to take antibiotic pre-medication prior to dental treatment?

Yes ○ No ○ Don't know ◉

Are you currently taking any medications? Yes ○ No ○

Types and dosage_____

_____

_____

Is there anything else we should know about your medical history?

_____

_____

To the best of my knowledge, the information provided is correct.

_____

Signature Date

Have you had or do you have:

Headaches Yes ○ No ○

Facial Pain (Non-specific) Yes ○ No ○

TMJ Pain Yes ○ No ○

Tender, Sensitive Teeth (Percussion) Yes ○ No ○

TMJ Noise Yes ○ No ○

Difficulty Chewing Yes ○ No ○

Limited Opening of the Jaw Yes ○ No ○

Neck Pain Yes ○ No ○

Ear Congestion Yes ○ No ○

Postural Problems Yes ○ No ○

Vertigo (Dizziness) Yes ○ No ○

Paresthesia of Fingertips (Tingling) Yes ○ No ○

Bell's Palsy Yes ○ No ○

Clinching / Grinding / Bruxing Yes ○ No ○

Nervousness / Insomnia Yes ○ No ○

TODD W. FRUIT, D.M.D.
Neuromuscular • Cosmetic • Restorative • Preventative

Name:_____

1: Reservations

In our office we consider appointments reservations and we reserve time specifically for you. Dr. Fruit and our hygiene team reserve one on one time and prepare the treatment room especially for you; we do not double book time with other patients. Once you have an appointment with our office we consider it confirmed. We don't like to interrupt your day. So, if you would like a courtesy call, let us know and we will be more than happy to contact you the day before your appointment. We do not charge for appointments cancelled 48 hours in advance. However, every appointment has costs associated with it. Therefore, after three (3) broken (cancelled or no-show) appointments within the 48 hour window, we will require payment in advance for future appointments. _____ - initial

2: Financials

To ensure the highest quality of dental services and dental health, Dr. Fruit is not a preferred provider for any insurance plan. Typically insurance plans pay for compromised treatment and hesitate to pay for ideal treatment. Insurance plans are also an agreement between you and your insurer and may not cover all fees for treatment and services provided by Dr. Fruit and his team. **However**, for visits < $300.00 we will file your benefits payable to us and settle any balance due with you after payment is received. Visits > $300.00, please be prepared to pay ½ of the total procedure the day of your visit. The remainder will be filed with insurance. If after 60 days, your benefits have not paid, the balance becomes your responsibility. _____ - initial

4: Warranty

Major dental work is covered on a pro-rated scale over 3 years. Warranty is void if the Doctor prescribed maintenance program is not followed. _____ - initial

5: Consent to Treatment

I do hereby authorize and request the performance of dental treatment for me by Todd W. Fruit, D.M.D., and any procedures deemed necessary for treatment. I understand Dr. Fruit and his assistant will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics and analgesics deemed advisable.

I understand any treatment plans presented, along with associated fees, may change depending upon time lapse from initial examination and diagnosis and actual treatment rendered date. Once treatment has been started, complications may arise, which dictate additional procedures and/or treatment. Dr. Fruit or the team will always advise me of any changes.

6: Notice of Privacy Practices and Disclosure of Health Information

I have been offered a copy of the Notice of Privacy Practices and have had the opportunity to read and consider the contents. This notice provides a description of our treatment, payment activities and healthcare operations, uses and disclosures we may make of your protected health history and information, as well as other important matters about your protected health information.

By signing this consent form, I understand I am giving consent for you to release and disclose my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

Or Guardian Signature for Minor Patient

You are entitled to a copy of this consent after signing.

TODD W. FRUIT, D.M.D.

Neuromuscular • Cosmetic • Restorative • Preventative

DENTAL RECORDS RELEASE

PATIENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY: _____

I REQUEST MY DENTAL RECORDS BE RELEASED TO THE FOLLOWING

DENTIST: DR: Todd W. Fruit, DMD

ADDRESS: 400 A Johnny Mercer Blvd.

Savannah, GA 31410

PHONE: 912-897-5788

EMAIL: toddfruitdental@comcast.net– (prefer digital records if available. Dexis or JPEG)

By signing below, you are authorizing _____to turn over your dental records to the dentist OR person you have designated above. If you have more than one family member in our practice, each adult family member should sign individual releases.

_____ _____

PATIENT OR GUARDIAN (specify relationship) DATE