Maple Springs Dental

PATIENT INFORMATION & HEALTH UPDATE

To keep your record accurate, please complete all sections, sign, and date below.

You may be required to update this form regularly.

Date: ___________________ Birth Date: ______/______/_____

Patient Name: ____
Last First MI

Phone (Home): ______________________ (Cell) _____________________ (Work) __________________

Email Address ____

Address: ____

Insurance: ____
Company Employer

Please list all current medications (include vitamins and store bought medications)

____

____

Are you required to premedicate with antibiotics prior to dental treatment, due to a heart murmur or joint replacement surgery? If so, what medication does your doctor prescribe?

____

Are your currently pregnant or trying to get pregnant? YES NO Due Date: __________

Tobacco Use- Cigarettes/ Vaping/ E-Cig/ Other: __________ How often: __________ Use: Current/ Past

Check all that apply:

- ☐ Acid Reflux/ Gerd
- ☐ AIDS

Allergic to
- ☐ Amoxicillin
- ☐ Codeine
- ☐ Latex
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____________

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints (where)___________
- ☐ Asthma (last attack)___________
- ☐ Blood Disease
- ☐ Cancer (type)_____________
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Easy Bruising
- ☐ Eating Disorder (type) ___________
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (type)_____
- ☐ HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pace Maker
- ☐ Radiation (where)___________
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery (type)_________
- ☐ Thyroid Disease
- ☐ Tuberculosis (when)________
- ☐ Tumors
- ☐ Ulcers
- ☐ Vertigo
- ☐ Venereal Disease
- ☐ **Other** _______________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment, without fail.

Signature: ____ Date: ____________________

GENERAL INSURANCE CONSENT FORM

As a courtesy, we submit insurance claims for our patients. The patient portion of your dental services is ***estimated and due at the time of service.*** This amount is subject to adjustment when the services or claims are paid by your insurance company. In addition, certain insurance companies have annual limitations for the number of dental services that can be reimbursed and for the amount they pay out per calendar year.

You, as a patient and/or legal guardian of a patient, are responsible for monitoring your insurance coverage. If for any reason your insurance does not pay the amount estimated at the time of service, ***you are responsible for the balance***.

Please sign below to acknowledge that you have read and understand the above statement.

____

Print Patient Name Here

____ ________________

Patient/Legal Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please read over attached ***Notice of Privacy Practice*** *before signing below.* You may refuse to sign this acknowledgement.

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

Patient Name ___________________________________

Patient Signature ____ Date ______________

Once this page has been signed, it will be placed in your records as written acknowledgement of receipt of the Notice of Privacy Practices.

Authorization for Release of Information

Our office is authorized to release protected health information about patient named above to the entities below. If none, please write NONE and sign & date.

Name	Relationship	Information to be disclosed	
_____________________________________	_____________	Dental	Financial
_____________________________________	_____________	Dental	Financial
_____________________________________	_____________	Dental	Financial

Patient Signature ____ Date _____________

NOTICE OF PRIVACY PRACTICES

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you with your authorization for several other reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the reception area. You can also request a copy of our notice at any time. For more information about our privacy practice, contact the office below.

YOUR RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

The following is a statement of your rights to your health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the US. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact our office.