PATIENT INFORMATION

Date: _____

Patient Name: _____ Preferred Name: _____
Last First Middle

Social Security: _____ DOB: ____/_____/_____ Email: _____

Phone (Home): _____ (Cell) _____ (Work) _____

Address: _____
Street Apt #

_____
City State Zip Code

☐ Male ☐ Female
☐ Married ☐ Single ☐ Child

Voicemail Confirmation YES/ NO
Text Confirmation YES/ NO
Email Confirmation YES/ NO

Patient Responsible Party (if other than patient)

Name: _____ DOB: ____/____/____ Relationship to Pt: _____

Please notify front desk if patient responsible party information (address/ phone etc) differs from Patient.

Insurance Information

Primary Policy Holder (PH): _____
Last First MI

PH SSN: _____ PH DOB: _____/ _____/ _____ PH Zip Code: _____

Insurance Company Name: _____ Employer Name: _____

Subscriber ID: _____ Group # _____

Ins. Address: _____ Ins. Phone Number _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Other _____

Please notify receptionist if you have a secondary insurance.

Referral Source - How did you hear about our office?

☐ Family/ Friend _____
☐ Doctor _____
☐ Local Advertisement _____
☐ Community Event _____
☐ Insurance Company _____
☐ Direct Mailer
☐ Apartment/ Home Packet
☐ Sign
☐ Internet: Google Facebook Yelp Yellow Pages
☐ Other _____

If you were referred to our office by another patient, may we include your name in a thank you letter to them? YES _____ NO _____

PATIENT HEALTH HISTORY AND CONSENT

Date:_____ **Birth Date:** _____/_____/_____

Patient Name: _____
Last First MI

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** _____

Have you ever had any complications following dental treatment including any issues with dental anesthetic or becoming numb? YES NO.

If yes, explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? YES NO

If yes, explain: _____

Are you now under the care of a physician? YES NO

Name of Physician: _____Specialty: _____ Phone: _____

PATIENT HEALTH HISTORY AND CONSENT (continued)

Are you happy with the appearance of your teeth/gums/smile? Yes No

Would you like to discuss enhancing the appearance of your smile? Yes No

What don't you like about your smile? _____

Would you like to discuss how to make your teeth WHITER? Yes No

Anything else you would like to discuss with the doctor? _____

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

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such dental care to the third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

I also give permission for the use of photographs and records made in the process of examination, treatment, and retention to be used for the purposes of research, education, or publication in professional journals.

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.