

Patient Information Form

Patient Name: _____ Home Phone: (____) _____ - _____

Address: STREET _____ Work Phone: (____) _____ - _____

CITY _____ STATE _____ ZIP _____ Mobile Phone: (____) _____ - _____

Sex: _____ Marital Status: _____ Birthday: ____ / ____ / ____ Social Security # _____ - _____ - _____

Patient E-Mail Address: _____ Does our office have permission to contact you via e-mail? Circle One **Yes** or **No**

Emergency Contact: _____ Primary Phone # (____) _____ - _____

Address: _____ Secondary Phone # (____) _____ - _____

Name of friend or relative not living with you _____ Home or cell phone # (____) _____ - _____

Dental Insurance Co.: _____ Policyholder Employer Name: _____

Employer Address: _____ Policyholder SSN# and/or Member ID#: _____ - _____ - _____

Policyholder Relationship to Patient: _____ Policyholder Birthday: ____ / ____ / ____ Group# _____ Insurance Phone # (____) _____ - _____

How did you hear about our office? _____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS? – INDICATE WITH AN (X)

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Allergic to any drugs or anesthetics – Please List: _____ <input type="checkbox"/> Do you now have or have you been exposed to HIV / AIDS? <input type="checkbox"/> Hepatitis or liver problems? <input type="checkbox"/> Joint replacement (Hip, knee, etc)? When? _____ <input type="checkbox"/> Any heart ailments (Vascular surgery, pacemaker)? <input type="checkbox"/> Mitral Valve Prolapse / Heart Murmur? <input type="checkbox"/> Rheumatic Fever? <input type="checkbox"/> Have you ever suffered a stroke? <input type="checkbox"/> Do you have high blood pressure? <input type="checkbox"/> Are you taking a blood thinner (Coumadin, Warfarin, Aspirin)? <input type="checkbox"/> Excessive bleeding from a cut or a dental extraction? <input type="checkbox"/> Have you ever taken Fosomax? (How long?) _____ <input type="checkbox"/> Do you have anemia or blood problems? <input type="checkbox"/> Tuberculosis? <input type="checkbox"/> Ulcer or colitis? <input type="checkbox"/> Epilepsy? <input type="checkbox"/> Kidney Problems? <input type="checkbox"/> Diabetes? | <ul style="list-style-type: none"> <input type="checkbox"/> Do you have arthritis? <input type="checkbox"/> Radiation Treatments? <input type="checkbox"/> Malignancies? <input type="checkbox"/> Nervous disorders, fainting, or dizziness? <input type="checkbox"/> Venereal disease? <input type="checkbox"/> Do you have asthma? <input type="checkbox"/> Hay fever or allergies in general? <input type="checkbox"/> Sinus problems? <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Cigarette, pipe, or cigar smoking? (How long?) _____ <input type="checkbox"/> Teeth sensitive to cold, heat, sweets, or pressure? <input type="checkbox"/> Clenching or grinding of teeth? <input type="checkbox"/> Gums bleed easily? <input type="checkbox"/> Past periodontal treatment? <input type="checkbox"/> Past orthodontic treatment? <input type="checkbox"/> Unfavorable dental experience? |
|--|--|

Physician's Name: _____ Date of last physical examination: ____ / ____ / ____

Are you currently under the care of a physician? If so, why? _____

What medicine, pills, or supplements are you taking now? _____

Chief oral complaint: _____

Date of last dental exam: ____ / ____ / ____ X-Rays: ____ / ____ / ____ Cleaning: ____ / ____ / ____

Authorization

I have reviewed the information on this questionnaire and it is accurate to best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.

If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: _____ Date: _____
(OR SIGNATURE OF PERSON AUTHORIZED TO CONSENT IF PATIENT IS UNDER 18 YEARS OF AGE)

| To be filled out by Doctor ONLY | UPDATED: | Initial | Date |
|--|-------------|---------|-------|
| Medical / Dental History Review | _____ | _____ | _____ |
| Doctor's Signature: _____ | Date: _____ | _____ | _____ |



HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

- *Treatment (including direct or indirect by other healthcare providers involved in my treatment).
- *Obtaining payment from third party payers (e.g. my insurance company)
- *The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of the notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and discussed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions.

Financial Policy

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your own care. We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat our personal situation. Please read and sign this form in order to proceed with your scheduled appointment.

Payment: The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made with the office manager. We welcome cash, checks and all major credit cards. If you choose to pay by card your bank will charge a 3% fee.

Insurance Assistance: Insurance claims are filed as a courtesy to you, our patient. Our goal is to maximize your insurance benefits and make any remaining balance easily affordable. Any portion, not expected to be covered by these benefits, is the responsibility of the patient and due at the time dental treatment is performed. This amount includes any deductibles and co-payments. Please understand that this is only an estimate; not a guarantee of payment, and is solely based on the information available to us from your insurance company.

Financial Assistance: Our fees are based on the quality of the materials we use and our experience in performing your needed treatment. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. To facilitate this goal, we are pleased to offer outside financing through CareCredit. Please ask our Office Manager for further details.

No Shows/Missed Appointments: We request notice to cancel or reschedule an appointment at least 48 hours in advance. If 48 hour notice is not given, a charge of \$50 may be assessed to the patient's account. For appointments scheduled longer than 1 hour, an additional \$25 will be charged for each hour missed.

Collections: When our office has made repeated attempts to collect a balance due, we may need to turn an account over to collections. The financially responsible party signing below shall pay all fees incurred while collecting on their family account.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

I also understand that any X-rays taken are the property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Signed _____
Signature of financially responsible Patient, Parent, or Guardian

Date _____