Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ **Occupation**: _____

Family Status: Married…Divorced…Single…Child…Other _____

Social Security # _____ **Birth Date**:____/____/____ **Gender:** Male / Female

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

Fax _____ Other _____E-mail Address:_____

Spouse, Parent or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment ☐ Male ☐ Female

Name:_____ Employer: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ SS #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber Employer's Name/Address _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Co. Name/Phone/Address:_____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Insurance ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

MEDICAL HISTORY

Indicate which of the following you have had, or have at present. Circle "yes or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Emphysema……	Yes	No	Cold Sores……	Yes	No
Chest Pain …….	Yes	No	Chronic Cough……	Yes	No	Fever Blisters……	Yes	No
Congenital Heart Disease..	Yes	No	Cancer……	Yes	No	Blood Transfusion……	Yes	No
Heart Murmur……	Yes	No	Tuberculosis ……	Yes	No	Hemophilia……	Yes	No
High Blood Pressure……	Yes	No	Asthma ……	Yes	No	Sickle Cell Disease……..	Yes	No
Mitral Valve Prolapse……	Yes	No	Hay Fever …….	Yes	No	Liver Disease……	Yes	No
Artificial Heart Valve…….	Yes	No	**Latex Sensitivity** ……..	Yes	No	Neurological Disorders…	Yes	No
Heart Stint/Shunt……	Yes	No	Allergies or Hives ……	Yes	No	Epilepsy or Seizures……	Yes	No
Heart Pacemaker……	Yes	No	Radiation Therapy…….	Yes	No	Fainting or Dizzy Spells..	Yes	No
Rheumatic Fever……	Yes	No	Chemotherapy……	Yes	No	Nervous/Anxious……..	Yes	No
Arthritis/Rheumatism……..	Yes	No	Tumors……	Yes	No	Psychiatric Care……	Yes	No
Stroke……	Yes	No	Hepatitis A (Infectious).	Yes	No	Sinus Trouble……...	Yes	No
Artificial Joints……	Yes	No	Hepatitis B (Serum)…...	Yes	No	**Allergy to Jewelry**…….	Yes	No
Kidney Trouble……	Yes	No	Venereal Disease……..	Yes	No	**Allergy to Metal**……..	Yes	No
Diabetes……	Yes	No	A.I.D.S.……	Yes	No	**TMJ Disorder**……..	Yes	No
Thyroid Problems……	Yes	No	H.I.V. Positive……	Yes	No	Smoke / Chew Tobacco..	Yes	No

What is the reason for your visit today? _____

Date of your last Cleaning? _____ **Last Full Mouth Set of X-rays?** _____

Do you have any health problems that need further clarification?..... Yes No
If yes, please explain _____

Do you have or have you had any disease, condition or problem not listed? Yes No
If yes, please list _____

Are you under the care of a physician? Yes No
If yes, please explain _____
Name of physician _____

Are you taking any medication, drugs or pills now? Yes No
If yes, please list: _____
_____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? Yes No
If yes, please list: _____

Have you ever been diagnosed with Periodontal "Gum" disease? Yes No
If yes, date of treatment _____

Women

Are you: **Pregnant?** Yes _____Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(Name of Patient)** _____**'s** dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Patient___ _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ **Relationship to Patient** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Please Print Your Name

Signature

Date

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

____ **Individual refused to sign**

____ **Communication barriers prohibited obtaining the acknowledgment**

____ **An emergency situation prevented us from obtaining acknowledgment**

____ **Other (Please Specify)**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of our privacy practices our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **3/14/05**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time, for more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in affect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use and disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.
We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information or provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using contact information listed at the end of this Notice. If you request copies, we will charge you **$1.00** for each page. **$10.00** per hour for staff time to locate and copy your health information, and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information, for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosing Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about you health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend you health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Human Health and Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Human Health and Services.

Contact Officer:_____

Telephone:_____ Fax_____

E-mail: _____

Address: _____

This form is educational only, does not constitute legal advice, and covers only federal, not state law (august 14, 2002)