Patient Information:

Date _____

SS# _____

Patient Name _____

Date of Birth _____ Sex ☐ M ☐ F

Address _____

City _____ State _____ Zip _____

E- mail _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/ School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Date of Birth _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance:

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Member ID _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Date of Birth _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with

_____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X_____

Date_____ Relationship to patient_____

Phone Numbers:

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

Spouse's Work (___) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (___) _____ Work Phone (___) _____

Dental History: Place a mark on "yes" or "no" to indicate if you have had any of the following:

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Bad breath ☐ Yes ☐ No

Bleeding Gums ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry Mouth ☐ Yes ☐ No

Food collection between teeth ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth pain when brushing? ☐ Yes ☐ No

Orthodontic treatmeant? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Sensitivity to hot/cold/sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

Health History:

Patient's Name: _____ Nickname: _____ Age_____

Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding abnormally, with	☐ Yes	☐ No	- Type_____			Swollen Feet or Ankles	☐ Yes	☐ No
Extractions or surgery			Herpes	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tumor or growth	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor/growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight loss, unexplained	☐ Yes	☐ No
- A1C _____			Radiation Treatment	☐ Yes	☐ No	Any surgeries	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	- _____		

Anything we missed? _____

Women:

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications:

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name _____

Phone (____)_____

Allergies:

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other _____

_____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Consent for Services and Financial Policy

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

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

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPPA Disclosure Form.**

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the **Privacy Act** to people other than yourself. I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding Myself.

_____

Please Print Name and Relationship

_____

Please Print Name and Relationship

_____

Please Print Name and Relationship

_____ _____

Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)