



Patient Information

Thank you for choosing our office! Prior to receiving dental care at our office, we need the following information completed. If you have any questions, please do not hesitate to ask us for assistance. All information will be confidential.

PATIENT'S NAME _____ TODAY'S DATE ____ / ____ / ____ CELL PHONE _____

PATIENT'S ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

EMAIL _____ Mark Preferred TEXTING []Yes []No

PATIENT'S AGE ____ PATIENT'S MARITAL STATUS []Single []Married Spouse/Parent or Guardian's Name _____

PATIENTS BIRTHDAY ____ / ____ / ____ GENDER []Male []Female PATIENT'S SOCIAL SECURITY # _____

PATIENT'S OCCUPATION _____ PATIENT'S EMPLOYER _____

IF PATIENT IS STUDENT, NAME OF SCHOOL _____

WHO MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE NUMBER _____

Responsible Party to Pay for Patient's Dental Services

NAME _____ RELATIONSHIP TO PATIENT _____ MARITAL STATUS []Single []Married

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ SOCIAL SECURITY # _____

BIRTHDAY ____ / ____ / ____ OCCUPATION _____ EMPLOYER _____

Dental Insurance Information

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDAY ____ / ____ / ____

SOCIAL SECURITY NUMBER _____ NAME OF EMPLOYER _____

INSURANCE COMPANY _____ GROUP # _____

INSURANCE COMPANY ADDRESS _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? []Yes []No If yes, complete the following

Secondary Dental Insurance Information

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDAY ____ / ____ / ____

SOCIAL SECURITY NUMBER _____ DATE EMPLOYED ____ / ____ / ____ NAME OF EMPLOYER _____

ADDRESS OF EMPLOYER _____

INSURANCE COMPANY _____ GROUP # _____

INSURANCE COMPANY ADDRESS _____

Regarding Insurance:

The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance company information and/or claim form.

All co-pays and deductibles are due at the time of appointment unless otherwise arranged by the Office Manager.

As a courtesy, we will assist you with your dental insurance. However, the responsibility for knowing the specifics of your insurance lies with YOU. We encourage you to familiarize yourself with your insurance benefits and its limitations. Insurance is a contract between you and the insurance company and our office is only a third party to that contract. Please contact your insurance company if you have questions about your plan.

Also, please be aware that treatment plan estimates are just that...ESTIMATES. We do our best to accurately determine treatment and associated co-payments before beginning treatment. We will inform you of any changes to your treatment as they arise. However, you are ultimately responsible for all balances on your account.

Authorization and Release

- I authorize your office to release any information related to my dental treatment, including any diagnosis and records or x-rays of any treatment or examination rendered to me during the period of such dental care, to any third party payors, insurance companies, and/or other health and dental practitioners.
- I authorize and request my insurance company, if any, to pay directly to your office the insurance benefits otherwise payable to me. Your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, your office may terminate this courtesy at any time.
- I understand that my dental insurance company and/or my responsible party may pay less than the actual bill for services. I agree to be solely responsible for full payment of all services rendered on my behalf or on the behalf of my dependents should for any reason my insurance company and/or my responsible party fail to pay or pay less than full for such services.
- I understand that my ESTIMATED co-payment is due in full at the time of treatment

X

Signature of patient (or parent/guardian if minor)

Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- 1.) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- 2.) Obtain payment from third-party payers.
- 3.) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Signature _____

Signature of patient (or parent/guardian if minor)

Medical & Dental History

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

Patient Name _____ Date _____

Medical History

Have you ever had the following: (circle "yes" or "no", leave blank if uncertain)

Pneumonia.....	no	yes	Anemia.....	no	yes	AIDS or HIV+.....	no	yes
Rheumatic Fever.....	no	yes	Cancer.....	no	yes	Stroke.....	no	yes
Heart Disease.....	no	yes	Glaucoma.....	no	yes	Emphysema.....	no	yes
Arthritis.....	no	yes	Lupus.....	no	yes	Hepatitis.....	no	yes
Heart Surgery.....	no	yes	Blood Transfusions.....	no	yes	Ulcer.....	no	yes
Osteoporosis.....	no	yes	Angina.....	no	yes	Kidney Disease.....	no	yes
Artificial Joints.....	no	yes	High Blood Pressure.....	no	yes	Thyroid Disease.....	no	yes
Epilepsy.....	no	yes	Low Blood Pressure.....	no	yes	Bleeding Tendency.....	no	yes
Migraine Headaches.....	no	yes	Eating Disorder.....	no	yes	Organ Transplant.....	no	yes
Tuberculosis.....	no	yes	Asthma.....	no	yes	Chest Pain.....	no	yes
Radiation Therapy.....	no	yes	Pacemaker.....	no	yes	Liver Disease.....	no	yes
Leukemia.....	no	yes	Diabetes.....	no	yes	Hives or Eczema.....	no	yes
Heart Attack.....	no	yes						

Previous Hospitalizations/Surgeries

Date of Last Physical _____ Current Physician _____ Phone: _____

Medications: (prescription) _____

Allergies to Medications? yes no

Vitamins: _____

Herbal Treatments: _____

Have you ever taken Fen-Phen/Redux No Yes Have you ever taken a drug for osteoporosis No Yes

Smoking : Never: _____ Previously, but quit: _____ Currently: _____

Chewing tobacco: Never: _____ Previously, but quit: _____ Currently: _____

Do you have any disease/condition not listed above that you think we should know about?

Dental History

Name and location of previous dentist _____

Date of Last Dental Exam _____

- | | |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. Have you had any head, neck or jaw injuries?.....no yes | 4. Do you clench or grind your teeth?.....no yes |
| 2. Are your teeth sensitive to hot or cold liquids/foods?.....no yes | 5. Do you bite your cheeks or lips frequently?.....no yes |
| 3. Have you experienced any of the following problems in your jaw? | 6. Do you have any sores or lumps in or near your mouth?... no yes |
| • Clicking.....no yes | 7. Do you feel any pain in any of your teeth?.....no yes |
| • Pain (joint, ear, side of face).....no yes | 8. Do your gums bleed while brushing or flossing?.....no yes |
| • Difficulty in opening or closing.....no yes | 9. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....no yes |
| • Difficulty in chewing.....no yes | 10. Do you like your smile?.....no yes |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature _____

Date _____

parent signature if under 18

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____

Reviewed Date _____ By _____