Name ______________________________ Date of Birth ______________

Address ______________________________ SSN ______________

City ______________________________ State __________ Zip __________

Home Phone __________ Work Phone __________ Cell Phone __________

Email Address ______________________________ Best Time to Contact You __________

May We Email or Text You?

____

PERSON RESPONSIBLE FOR INSURANCE

Name ______________________________ Relationship ______________

Address ____

Social Security Number ______________________ Date of Birth ______________

Employer ______________ Home Phone ______________ Cell Phone ______________

Patient Consent Form

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

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy containing a more complete description of the uses and disclosures of my health information. I have given the right to review such Notice of Privacy prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that request in writing that you restrict how my private information is used or disclosure to carry out treatment, payment of health care operations.

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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________

Signature: ______________________

Relationship: ______________________

Date: ______________________

PATIENT MEDICAL HISTORY

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A If yes, please explain: ______

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A If yes, please explain: ______

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A If yes, please explain: ______

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A If yes, please explain: ______

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A ______

Are you on a special diet? ◯ Yes ◯ No ◯ N/A ______

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______

Do you have or have you had, any of the folllowing?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A ______

Are you happy with your smile? ◯ Yes ◯ No

If no, what would you change? ______

Whom may we thank for referring you to our office? ______

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

______

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______

FINANCIAL POLICY

Your insurance company is a contract between you, the insured, and the insurance company. The dental provider is not part of that contract. As a courtesy and service to you, we will file claims for you. Estimated co-payments and deductibles will be collected at the time of service. If your insurance company does not pay the claim in full, you will be responsible for payment of the remaining balance. By signing below, I understand and agree that I am ultimately responsible for my insurance co-payment, deductible, and any other procedures or fees not paid for or covered by my insurance company.

All balances will be due sixty days from the day of service, despite the actions of your insurance company. Monthly statements will be sent keeping you informed of the status of your account. We reserve the right to refer your account to a collection agency for any balance that remains ninety days from the date of service. We reserve the right to add additional collection fees up to 40% of the balance submitted to the collection agency and reasonable attorney fees.

Signature of Parent, Patient or Guardian ______ Date ______