Patient Information

Patient Name:_____ ❑Married ❑Single ❑Child Today's Date: _____

Address: _____

Social Security #: _____ e-mail: _____ Birth Date: _____

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

Health Information

Date of your last Dental visit: _____ Reason for *TODAY'S* visit: _____

Do you currently *have* or *ever had* any of the following? *Please check all that apply:*

❑ AIDS / HIV	❑ Cancer	❑ Jaundice	❑ Stroke
❑ Allergies:	❑ Chemotherapy	❑ Kidney Disease	❑ Tuberculosis
_____	❑ Diabetes	❑ Liver Disease	❑ Tumors
❑ Anemia	❑ Dizziness / Fainting	❑ Mental Disorders	❑ Ulcers
❑ Arthritis	❑ Epilepsy	❑ Mitral Valve Prolapse	❑ Venereal Disease
❑ Artificial Joints:	❑ Excessive Bleeding	❑ Pacemaker	❑ **I AM ALLERGIC TO:**
_____	❑ Glaucoma	❑ Pregnancy	❑ Codeine / Percocet ……
❑ Asthma	❑ Hay Fever	❑ Radiation Treatment	❑ Penicillin/Amoxicillin
❑ **BISPHOSPHONATES:**	❑ Head Injuries	❑ Respiratory Problems	❑ Erythromycin
❑ Osteoporosis	❑ Heart Disease/Surgery	❑ Rheumatic Fever	❑ Tetracycline
❑ IV: (Zometa, Arenia)	❑ Heart Murmur	❑ Rheumatism	❑ Lidocaine / Epinephrine
❑ Oral: (Fosamax, Actonel)	❑ Hepatitis	❑ Sinus Problems	❑ Advil / Motrin / Tylenol….
❑ Blood Diseases	❑ High Blood Pressure	❑ Stomach Problems	❑ Latex
			❑ Please sign our HIPAA form

- Have you ever had complications following dental treatment (including anesthetics)? ❑Yes ❑No
- Any hospital admission or emergency care within the past two years? ❑Yes ❑No
- Are you under the care of a physician? ❑Yes ❑No Physician's name/#:_____
- Do you have any health problems that require further clarification? ❑Yes ❑No (If yes, please inform the staff.)

*** Please list any medications you are currently taking, the reason for the medicine and the dosage: ***

Medicine Name	Reason for Taking Medicine	Dosage

To the best of my knowledge, all the information provided is true and correct. If I ever have any change in my health I will inform the staff.

❑Patient ❑Parent ❑Guardian Signature:_____ Date:_____

Employment Information

The Following information is for: ❑ The Patient ❑ The Person Responsible for Payment on the Account

Employer Name: _____ Occupation: _____

Employer Address: _____

Insurance Information

Primary Dental Insurance:

Name of INSURED: _____ Is INSURED a Patient? ❑ Yes ❑ No

INSURED's Birthdate: _____ SS #: _____

Insurance Plan Name and Address: _____

Insurance Plan Group #: _____ ID #: _____

INSURED's EMPLOYER NAME: _____

INSURED's EMPLOYER ADDRESS: _____

PATIENTS relationship to the Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary Dental Insurance:

Name of INSURED: _____ Is INSURED a Patient? ❑ Yes ❑ No

INSURED's Birthdate: _____ SS #: _____

Insurance Plan Name and Address: _____

Insurance Plan Group #: _____ ID #: _____

INSURED's EMPLOYER NAME: _____

INSURED's EMPLOYER ADDRESS: _____

PATIENTS relationship to the Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Privacy Practices: HIPAA Acknowledgement

This office adheres to all HIPAA Privacy Standards and Practices. We protect your sensitive information and have taken every possible step to safeguard against unauthorized use. Your personal records regarding your dental treatment received at our office stays in this office unless you allow us to share that information with another entity. There are, however, some instances that we need to be able to share your information. For example:

- Communication with our Dental Laboratories when fabricating prostheses
- Communication with Pharmacies when we call in medications
- Communication with Specialists that we refer you to
- Communication with Insurance Companies

This list is not 100% inclusive, and there may be other circumstances that your records are shared, but we will always alert you and get your approval prior to releasing any information.

Please provide names, relationship and phone numbers of who you allow us to discuss your treatment with:

1._____

2. _____

3._____

X_____

My signature above is my confirmation that I understand this office's HIPAA policies and procedures.

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 our patients to pay for the costs incurred for your care. Your financial responsibility MUST be determined before treatment. If you have dental insurance, ***please understand that my relationship is WITH YOU, not your dental insurance company***. IF THEY DENY PAYMENT, for any reason, you are solely responsibility for the charges incurred in full. We never assume your insurance company will pay your dental charges.

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

X_____ _____

Signature of: ❑Patient ❑ Parent ❑Guardian ❑Guarantor of payment Date