

Who may we thank for this referral? _____

Patient's Name: _____ Preferred Name: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
__ Married __ Single __ Male __ Female Age: _____ Birthdate: _____ Social Security #: _____
E-mail: _____

Person Responsible for Account (if other than above): _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
__ Married __ Single __ Male __ Female Age: _____ Birthdate: _____ Social Security #: _____
Employer's Name: _____ Employer's Phone: _____
Employer's Address: _____ City: _____ Zip: _____

Primary Dental Insurance Coverage __ No Insurance
Subscriber's Name: _____ Birthdate: _____ Social Security #: _____
Relationship to Subscriber: __ Self __ Spouse __ Child __ Other
Name of Insurance Carrier: _____
Insurance Carrier Phone: _____ Group #: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 r health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Initial
I give my permission to have my name or the names of my dependent family members on the computer schedule. _____ Initial
I give my permission to be reminded of my/our appointments via postcard or phone message reminders. _____ Initial
I authorize the release of photos and X-rays for professional and educational use as needed. _____ Initial
I authorize the release of dental information to parties responsible for account charges. _____ Initial

OFFICE POLICIES

For your convenience, we will confirm your appointments at your home phone number. A 48 hour (two working days) notice of schedule changes will be necessary to avoid a \$75.00 late cancellation fee.
The financial obligation for you dental treatment is between you and this office and may depend upon insurance coverage and vary accordingly.
The patient co-pay information that we provide to you is information based upon contract information provided to us by your insurance carrier and in no way guarantees payment. Any unpaid insurance monies for y our treatment will then become your responsibility.
Billing your insurance carrier is a courtesy provided to you by this office. We will make every attempt to collect payments in a timely manner. If, however, insurance monies haven't been received after 90 days of treatment, the balance is therefore your responsibility and all insurance monies for that treatment will be sent to you from your carrier.
We do not accept assignment of benefit for secondary insurance coverage. You will be provided with a statement of services for the purpose of filing your claim with your secondary insurance company.

Patient Name: _____ Date: _____
Signature: _____
Relationship to Patient: _____
Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

__ The patient refused to sign __ Communication Barriers __ Emergency Situation __ Other

Medical History Name of Physician: _____

Date of Last Exam: _____

Estimate of Your General Health: ___ Poor ___ Fair ___ Good

Current Weight: _____

Check if you have, or ever had the following:

- ___ Asthma, Hay Fever, Sinusitis, or other Allergies
___ Allergy to Penicillin, Aspirin, Local Anesthetic, Codeine, Fluoride or Other Drugs
___ Blood pressure, Heart Problems or Stroke
___ Rheumatic Fever or Heart Murmur
___ A Pacemaker or Open Heart Surgery
___ Diabetes, Liver, Kidney, Thyroid, or Lung Problems
___ Ulcers or Stomach Problems
___ Epilepsy or Nervous Disorders
___ Arthritis
___ Radiation Treatments or Chemotherapy
___ Male-Prostate Disorders
___ Anemia, Bleeding or Clotting Disorders
___ Herpes, HIV
___ Artificial Prosthesis
___ Contact Lenses or Glaucoma
___ Emotional Problems or Psychiatric Treatment
___ Alcohol/Drug Dependency
___ Heavy Smoker
___ Female - Taking Birth Control Pills
___ Female - Pregnant? Due Date _____
___ Female - Nursing Mother?

Are you required to Pre-Medicate before dental treatment? No Yes

List any current medication taken: _____

List any medication taken within the last 2 years: _____

Are you taking Tagamet (Cimetidine)? No Yes If Yes, which ones? _____

Are you taking any herbal supplements/medicines? No Yes If Yes, which ones? _____

Do you take antacids? No Yes If yes, how often? _____

Dental History Name of Previous Dentist: _____ Last Exam: _____ Last X-rays: _____

Reason for Seeking Treatment: _____

Check if you have, or ever had the following:

- ___ Unhappiness with the appearance of your teeth
___ Unfavorable dental experiences or dental fears
___ Problems with the effectiveness or bad reaction to dental anesthetic
___ Orthodontic treatment (braces) When? _____
___ Periodontal (gum) treatment. When? _____
___ Bleeding gums
___ Avoid brushing any part of your mouth
___ Sensitivity to temperature in any part of your mouth
___ Sore Teeth
___ A burning sensation in your mouth
___ Difficulty swallowing
___ An unpleasant taste or odor in your mouth
___ TMJ (jaw) problems
___ Noises in your jaw during opening or closing
___ Difficulty opening your mouth widely
___ Stiff neck muscles
___ Tension headaches
___ Clenching or grinding teeth during night or day
___ Loss of any teeth
___ Complete or partial denture

I understand that 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 change in my health and medication.

Signed: _____ Date: _____

Doctor Signature: _____ Date: _____

Office Use Only

ASA: I II III IV

Multiple horizontal lines for office use only.