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 _____

PERSON RESPONSIBLE FOR PATIENT'S FINANCES

Name _____ DOB _____ Relationship _____

Address _____ SSN # _____

Home Phone _____ Work Phone _____ Cell Phone _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 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
- ❑ Alzheimer 's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Heart Trouble /Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No ○ N/A If yes, please explain: _____

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 _____