PLEASE COMPLETE THE FOLLOWING. IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____

EMAIL ADDRESS: _____

NAME OF EMPLOYER (Please provide if you have insurance benefits through your employer) _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____
IF REFERRED TO US BY ANOTHER PATIENT, PLEASE PROVIDE THEIR NAME: _____

INSURANCE INFORMATION

NAME OF INSURANCE: _____

NAME OF SUBSCRIBER: _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER ID# OR SSN: _____

RELATIONSHIP TO PATIENT: _____

**IF COVERED UNDER TRICARE, PLEASE PROVIDE SUBSCRIBERS RANK: _____

DO YOU HAVE A SECONDARY INSURANCE PLAN?

NAME OF INSURANCE: _____

NAME OF SUBSCRIBER: _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER ID# OR SSN: _____

RELATIONSHIP TO PATIENT: _____

**IF COVERED UNDER TRICARE, PLEASE PROVIDE SUBSCRIBERS RANK: _____

Patient Name: _____ **Date of Birth:** _____

DENTAL HISTORY (Please circle appropriate answer, leave blank if you do not understand the question)

Yes / No Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last known dental exam: _____ Last Cleaning: _____

Yes / No Are you in pain now?
If YES, explain: _____

Yes / No Do your gums bleed while brushing or flossing your teeth?
Yes / No Are your teeth sensitive to hot or cold liquids/foods?
Yes / No Do you have any sores or lumps in or near your mouth?
Yes / No Have you had any head, neck, or jaw injuries?
If YES, explain: _____

Yes / No Do you clench or grind your teeth?
Yes / No Do you wear a Nightguard?
Yes / No Do you wear any removable appliances? (IE: Dentures, Partials, Retainers)
Yes / No Have you ever been or are currently required to take Antibiotics prior to your dental appointment?

MEDICAL HISTORY

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Yes / No Persistent Cough
Yes / No Blurred Vision
Yes / No Heart Attack or Stroke
Yes / No Heart Disease
Yes / No Heart Murmur
Yes / No Pacemaker or Stent
Yes / No High Blood Pressure
Yes / No Low Blood Pressure
Yes / No Anemia
Yes / No Stomach Problems or Ulcers
Yes / No Rheumatic Fever
Yes / No Seizures
Yes / No Epilepsy
Yes / No Skin Disease
Yes / No Psychiatric Care
Yes / No Eating Disorders
Yes / No Sinus Problems
Yes / No Recent Significant Weight loss
Yes / No Bleeding Problems
Yes / No Osteoporosis
Yes / No Chemotherapy
Yes / No Radiation Therapy
Yes / No Tumors or Cancer
If YES, type: _____
Yes / No Hepatitis
If YES, Type: _____

Yes / No Frequent Headaches
Yes / No Chest Pains
Yes / No Fibromyalgia
Yes / No Diabetes
Yes / No Kidney or Bladder Disease
Yes / No Hormone Therapy
Yes / No Sexually Transmitted Disease
Yes / No Asthma
Yes / No Thyroid Problems
Yes / No Liver Disease
Yes / No Emphysema or other lung disease
Yes / No Arthritis
Yes / No AIDS or HIV (Circle which one)
Yes / No Canker or Cold Sores
Yes/ No Herpes
Yes / No Dry Mouth
Yes / No Fainting or Dizziness
Yes / No Ringing in Ears
Yes / No Tuberculosis
Yes / No Glaucoma
Yes / No Allergies (or Hay Fever)
Yes / No High Cholesterol
Yes / No Artificial Joints
If YES, type: _____ Date: _____
Yes / No Transplant
If YES, type: _____ Date: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes / No Are you or could you be pregnant? If YES, how many months? _____
Yes / No Are you nursing?
Yes / No Are you using Birth Control? If YES, type: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS?

Yes / No	Recreational Drugs	Yes / No	Supplements (including herbal)
Yes / No	Antidepressants	Yes / No	Tobacco in any form
Yes / No	Weight loss medications	Yes / No	Aspirin
Yes / No	Bisphosphonate (Fosamax)	Yes / No	Antibiotics
Yes / No	Opioids (Ex: Norco, Vicodin, Percocet, Percodan)		

***PLEASE LIST ALL CURRENT MEDICATIONS** (Prescription & OTC)

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

Yes / No	Aspirin	Yes / No	Valium or sedatives	Yes / No	Metal
Yes / No	Antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Local Anesthetics	Yes / No	Codeine or other Opioids		

If answered YES to any of the above, please specify: _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Are you currently under medical treatment now?
If YES, for what? _____

Yes / No Are there any issues or conditions that you would like to discuss with the Dentist in private?

The practice of dentistry involves treating the whole person. If the Dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the Dentist to contact my physician.

Patient Signature: _____ Date: _____

Physician's Name: _____

Physician's Phone Number: _____

Whom may we contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my Dentist of any change in my health and/ or medications. Further, I will not hold my Dentist, or any other member of their staff, responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of Patient (or Guardian) Date

_____ _____

Dentist Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By Signing this form, I understand that:

1. **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
2. **The practice reserves the right to change the privacy policy as allowed by law.**
3. **The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.**
4. **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
5. **The practice may condition receipt of treatment upon execution of this consent.**

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed & their relation to you: _____

Print Patient Name: _____

Print Name of Guardian (if under the age of 18): _____

Signature of Patient or Guardian: _____ Date: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, CareCredit and Lending Point. Outside financing is available upon request and approval. Additional fees will be applied for returned checks.

Do you have insurance?

- We will file all dental claims to your insurance directly. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility.
- All charges you incur are your responsibility, regardless of your insurance coverage.
- This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid.

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. To provide the best services to our patients, we require at least a 48-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office are due and payable at the time services are rendered.

Signature of Patient or Guardian: _____

Date: _____