# Patient Information

Patient Name: ________________________________________ Date: ________
Last First MI

Gender: ___ Male ___ Female Family Status: ___ Married Single

Social Security #: ____________________ Birth Date: ____________

Phone (Home): ______________ (Work): ____________ Ext: ____ Cell: ________

Address: __________________________________________________
Street Apartment #

__________________________________________________
City State Zip code

Employer:: ____________________ Occupation: ____________________

# Insurance Information

PRIMARY:

Name of Insured: ________________________________________
Last First MI

Birth Date: __________ SS# ____________________ Group# ______________

Employer: ____________________ Insurance Company: ____________________

SECONDARY:

Name of Insured: ________________________________________
Last First MI

Birth Date: __________ SS# ____________________ Group# ______________

Employer Name: ____________________ Insurance Company: ____________________

General Dental Office: ________________________________________

Referred By: ________________________________________

## Consent for Services

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Payment is due in full at time of appointment,unless payment arrangements have been made prior in writing.

I agree to pay for all services rendered. **This office does not provide any type of financing**. In the event that full payment is not recieved within (60) days of receipt of statement, a late fee of $25 will be added each month. After a total of two statements, along with late fees, the account will be turned over to a collection agency. If a collection agency's services are required, I further agree to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees(30%) in connection with my debt. I also understand that to collect the debt my credit history may be checked through the use of my social security number, and any other information given. I understand that all fees incurred for dental treatment are my total responsibility, regardless of any insurance I may have. In the event my insurance does not provide benefits or reduced benefits, I am financially responsible to pay the agreed upon fee schedule.

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

______________________________ Date: __________ Relationship to patient: __________

Signature of patient, parent or guardian

# MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING? PLEASE CIRCLE YES OR NO:

History of AIDS/HIV.............. Yes No
Hepatitis.............................. Yes No
What Type ___________
When Treated ___________
Cancer .............................. Yes No
Chemotherapy....................... Yes No
Dates(s) ___________
Radiation ............................ Yes No
Area ___________
Heart Problems..................... Yes No
Explain ___________
Cardiac Pacemaker................. Yes No
High or Low Blood Pressure...... Yes No
Stroke................................ Yes No
Diabetes............................. Yes No
Last tested for sugar ___________
Kidney Disorder.................... Yes No

Liver Disorder...................... Yes No
Anemia............................. Yes No
Excessive Bleeding............... Yes No
Asthma............................. Yes No
Breathing/Respiratory Problems Yes No
Ulcers/Stomach Problems........ Yes No
Glaucoma........................... Yes No
Narrow or Wide Angle___________
Epilepsy/Convulsions............. Yes No
Dizziness/Fainting................ Yes No
Joint Replacement or Implant.... Yes No
Tuberculosis........................ Yes No
Hyper or Hypo Thyroid........... Yes No
Latex Allergy....................... Yes No
Any other conditions? ................. Yes No
Explain ___________

**Have you ever taken osteoporosis drugs such as FOSAMAX, BONIVA, ACTONEL or any cancer medications containing BISPHOSPHONATES?** ______

Do you smoke or use tobacco products? ______

Do you take ASPIRIN daily or several times a week? ______

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU ARE NOW CURRENTLY TAKING:

___________ ___________

___________ ___________

___________ ___________

LIST ANY ALLERGIES TO ANY DRUGS OR MEDICATIONS:

___________ ___________

When was you last visit to your physician? ___________ Reason? ___________

Have you been hospitalized or had any surgeries in the last two years? ___________

Reason? ___________

FEMALES: Are you pregnant? ______ Nursing? ______ Taking oral contraceptives? ______

Signature ___________ Date___________

Print Name ___________

# Notice of Privacy Practices

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.**

## OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about privacy practices, legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect October 8, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices at any time. Any new notices will be available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies please contact us.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**TREATMENT:** We may use and disclose your information to a physician or other healthcare provider providing treatment to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you.

**YOUR AUTHORIZATION:** You may give us written authorization to disclose your healthcare information to anyone for any purpose. You then may revoke this in writing at any time. Unless you give us written authorization, we cannot use of disclose your health information for any reason except those described in this notice.

**YOUR FAMILY AND FRIENDS:** We may disclose your information to any person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. In the event of your incapacity or emergency circumstances, we will disclose your health information using our professional judgment. We will also use our judgment with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, supplies, and x-rays or similar forms of health information. We may also disclose your health information when required to do so by law.

**ABUSE OR NEGLECT:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you information to the extent necessary to avert a serious threat to your health or safety or the heath and safety of others.

# Acknowledgement of Receipt

**I, ______________________________, have reviewed a copy of this office's Notice of Privacy Practices.**

______________________________

**Signature**

______________________________

**Date**