PATIENT NAME: _____

GENERAL PATIENT INFORMATION

PATIENT LAST NAME _____

PATIENT FIRST NAME _____

PATIENT MIDDLE NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

GENDER

☐ FEMALE ☐ MALE

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

STUDENT STATUS

☐ FULL TIME ☐ PART TIME

NAME OF SCHOOL _____

EMPLOYMENT STATUS

☐ FULL TIME ☐ PART TIME ☐ RETIRED

EMPLOYER _____

REFERRED BY _____

HAVE YOU BEEN SEEN BY OUR PRACTICE ?

☐ YES ☐ NO

HAS A FAMILY MEMBER BEEN SEEN OUR PRACTICE ?

☐ YES ☐ NO

CONTACT INFORMATION

ADDRESS _____

_____

_____

EMAIL ADDRESS _____

HOME PHONE _____

CELL PHONE _____

I GIVE PERMISSION TO LEAVE MESSAGES REGARDING MY MEDICAL, DENTAL AND FINANCIAL INFORMATION VIA THE FOLLOWING:

☐ VOICEMAIL ☐ TEXT ☐ EMAIL

EMERGENCY CONTACT

NAME _____

PHONE NUMBER _____

RELATIONSHIP TO PATIENT _____

PATIENT NAME: _____

MEDICAL CONTACT INFORMATION

PRIMARY DOCTOR ADDRESS / CONTACT	SPECIALIST ADDRESS / CONTACT	PHARMACY ADDRESS / CONTACT
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELEASE OF INFORMATION

I GIVE PERMISSION TO RELEASE MY MEDICAL, DENTAL AND FINANCIAL INFORMATION TO THE PERSON LISTED BELOW.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
_____	_____	_____

PATIENT NAME: _____

PRIMARY DENTAL INSURANCE

NAME OF EMPLOYER

_____

EMPLOYER ADDRESS

_____

_____

_____

EMPLOYER PHONE NUMBER

_____

INSURANCE PROVIDER COMPANY NAME

_____

POLICY #

_____

ID #

_____

GROUP #

_____

SOCIAL SECURITY # OF INSURED PARTY

_____

NAME OF INSURED PARTY

_____

ADDRESS OF INSURED PARTY

_____

_____

_____

PHONE NUMBER OF INSURED PARTY

_____

RELATIONSHIP TO PATIENT

_____

DATE OF BIRTH OF INSURED PARTY

_____

SECONDARY DENTAL INSURANCE

NAME OF EMPLOYER

_____

EMPLOYER ADDRESS

_____

_____

_____

EMPLOYER PHONE NUMBER

_____

INSURANCE PROVIDER COMPANY NAME

_____

POLICY #

_____

ID #

_____

GROUP #

_____

SOCIAL SECURITY # OF INSURED PARTY

_____

NAME OF INSURED PARTY

_____

ADDRESS OF INSURED PARTY

_____

_____

_____

PHONE NUMBER OF INSURED PARTY

_____

RELATIONSHIP TO PATIENT

_____

DATE OF BIRTH OF INSURED PARTY

_____

PATIENT NAME: _____

MEDICAL HISTORY

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

_____

_____

CARDIOVASCULAR SYSTEM

Y	N	
☐	☐	**ARE YOU CURRENTLY UNDER THE CARE OF A CARDIOLOGIST?**
		IF YES, NAME OF CARDIOLOGY PRACTICE:
		_____
☐	☐	**MITRAL VALVE PROLAPSE**
☐	☐	**CHEST PAIN, ANGINA**
☐	☐	**HEART ATTACK OR STROKE**

Y	N	
☐	☐	**HEART PALPITATIONS OR FLUTTER**
☐	☐	**HIGH BLOOD PRESSURE**
☐	☐	**RHEUMATIC FEVER**
☐	☐	**OTHER HEART OR VESSEL DISEASE**
		IF YES, PLEASE DESCRIBE:
		_____

PULMONARY SYSTEM

Y	N	
☐	☐	**ASTHMA**
☐	☐	**BRONCHITIS (PAST 3 MONTHS)**
☐	☐	**CHRONIC OBSTRUCTIVE LUNG DISEASE**
☐	☐	**EMPHYSEMA**
☐	☐	**SHORTNESS OF BREATH**
☐	☐	**SLEEP APNEA**

Y	N	
☐	☐	**PNEUMONIA (PAST 3 MONTHS)**
☐	☐	**PRODUCTIVE COUGH**
☐	☐	**NASAL CONGESTION**
☐	☐	**NOSE BLEEDS**
☐	☐	**SMOKING / TOBACCO PRODUCTS**
		IF YES, FOR HOW LONG:
		_____

WOMEN

Y	N	
☐	☐	**ARE YOU PREGNANT OR PLANNING PREGNANCY?**

Y	N	
☐	☐	**ARE YOU NURSING?**

PATIENT NAME: _____

OTHER

Y	N	
☐	☐	HEPATITIS
☐	☐	DIABETES
☐	☐	THYROID DISEASE
☐	☐	EPILEPSY / CONVULSIONS
☐	☐	GLAUCOMA
☐	☐	FAINTING EPISODES
☐	☐	BLEEDING PROBLEMS
☐	☐	VENEREAL OR AIDS DIAGNOSIS
☐	☐	BLOOD TRANSFUSION
☐	☐	TUBERCULOSIS
☐	☐	EMOTIONAL / MENTAL HEALTH PROBLEMS
☐	☐	MOTION SICKNESS
☐	☐	KIDNEY DISEASE
☐	☐	SICKLE CELL DISEASE
☐	☐	MUSCULAR DISEASE
☐	☐	PARKINSON'S DISEASE
☐	☐	WEAR CONTACT LENSES / GLASSES
☐	☐	TMJ
☐	☐	SURGICAL JOINT REPLACEMENTS
☐	☐	OSTEOPOROSIS / OSTEOPENIA

Y	N	
☐	☐	ARE YOU PRESENTLY UNDER A DOCTOR'S CARE FOR ANY REASON? *IF YES, PLEASE DESCRIBE:*
		_____
☐	☐	HAVE YOU HAD A PROBLEM WITH LOCAL ANESTHESIA? *IF YES, PLEASE DESCRIBE:*
		_____
☐	☐	DO YOU USE ALCOHOL? *IF YES, HOW MUCH:*
		_____
☐	☐	HAVE YOU HAD RADIATION TREATMENTS? *IF YES, PLEASE DESCRIBE DATE, AREA AND AMOUNT OF RADIATION:*
		_____
☐	☐	DO YOU HAVE ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?
☐	☐	ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BONE DENSITY MEDS OR BISPHOSPHONATES SUCH AS FOSAMAX, BONIVA, ACTONEL, IV-ZOMETA, AREDIA, XGEVA, PROLIA, OR RECLAST IN THE PAST 12 YEARS?
☐	☐	HAS A PHYSICIAN OR PREVIOUS DENTIST RECOMMENDED THAT YOU TAKE ANTIBIOTICS PRIOR TO YOUR DENTAL TREATMENT? *IF YES, FOR WHAT REASON:*
		_____
☐	☐	IS THERE ANY OTHER CONDITION NOT LISTED ON THIS FORM THAT YOU FEEL WE SHOULD BE MADE AWARE OF? *IF YES, PLEASE DESCRIBE:*
		_____
		_____
		_____

ALLERGIES

Y	N	
☐	☐	ARE YOU ALLERGIC TO LATEX OR RUBBER PRODUCTS?

Y	N	
☐	☐	ARE YOU ALLERGIC TO LOCAL ANESTHETIC OR NUMBING MEDS?
☐	☐	ARE YOU ALLERGIC TO ANY MEDICATIONS? *IF YES, PLEASE LIST:*
		_____
		_____

PATIENT NAME: _____

MEDICATIONS LIST ALL MEDICATIONS YOU ARE TAKING BELOW. PLEASE INCLUDE PRESCRIPTION, NON-PRESCRIPTION, HOMEOPATHIC OR HERBAL, INHALERS, INJECTIONS, OR RECREATIONAL DRUGS.

NAME OF MEDICATION	DOSAGE	CONDITION

NOTE: IF YOU ARE USING ORAL CONTRACEPTIVES IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES. PLEASE CONSULT YOUR PHYSICIAN FOR FURTHER GUIDANCE.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DOCTOR, OR ANY OTHER MEMBER OF HIS / HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

SIGNATURE *DATE*

(COMPLETED BY STAFF ONLY)

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

PATIENT NAME: _____

FEES & PAYMENTS

WE MAKE EVERY EFFORT TO KEEP DOWN THE COST OF YOUR CARE. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT. REGARDLESS OF ANY INSURANCE STATUS, YOU ARE RESPONSIBLE FOR THE BALANCE DUE ON YOUR ACCOUNT. YOU ARE RESPONSIBLE FOR ANY AND ALL PROFESSIONAL SERVICES RENDERED. AS A COURTESY TO YOU, OUR OFFICE PROVIDES CERTAIN SERVICES, INCLUDING PRE-TREATMENT ESTIMATES WHICH WE CAN SEND TO THE INSURANCE COMPANY AT YOUR REQUEST. IT IS PHYSICALLY IMPOSSIBLE FOR US TO HAVE KNOWLEDGE AND KEEP TRACK OF EVERY ASPECT OF YOUR INSURANCE.

PLEASE BE AWARE SOME OR PERHAPS ALL OF THE SERVICES PROVIDED MAY OR MAY NOT BE COVERED BY YOUR INSURANCE POLICY. IT IS UP TO YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE AS TO WHAT BENEFITS YOUR EMPLOYER HAS PURCHASED FOR YOU. IF YOU HAVE ANY QUESTIONS CONCERNING THE PRE-TREATMENT ESTIMATE AND/OR FEE FOR SERVICE, IT IS YOUR RESPONSIBILITY TO HAVE THESE ANSWERED PRIOR TO TREATMENT TO MINIMIZE ANY CONFUSION ON YOUR BEHALF. FULL PAYMENT IS DUE AT THE TIME OF SERVICE. IF INSURANCE BENEFITS APPLY, ESTIMATED PATIENT CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCES ARE DUE AT THE TIME OF SERVICE. ANY BALANCE IS YOUR RESPONSIBILITY WHETHER OR NOT YOUR INSURANCE COMPANY PAYS ANY PORTION.

_____ _____

SIGNATURE *DATE*

THIS SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT TO THIS DOCTOR NAMED OF THE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____

SIGNATURE *DATE*

OUR FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE AND WOULD BE HAPPY TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR FINANCIAL RESPONSIBILITY. IF YOU DO NOT HAVE INSURANCE, WE EXPECT PAYMENT IN FULL FOR ALL TREATMENT AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN PREVIOUSLY MADE. WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.

PATIENT NAME: _____

REGARDING INSURANCE

IF YOU HAVE INSURANCE, WE CAN ASSIST YOU IN SUBMITTING YOUR CLAIM. YOUR INSURANCE CLAIM WILL ONLY BE COMPLETED AND SUBMITTED IF WE ARE PROVIDED WITH ALL PERTINENT INSURANCE COMPANY INFORMATION. IT IS YOUR RESPONSIBILITY TO VERIFY THAT YOUR POLICY IS IN EFFECT AT THE TIME YOUR SERVICES ARE PERFORMED. OTHERWISE, YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

UNFORTUNATLEY, WE MAY NOT BE AWARE OF YOUR SPECIFIC PLANS LIMITATIONS WHICH MAY RESULT IN A PAYMENT THAT DIFFERS FROM OUR ESTIMATED OR ACTUAL COST OF YOUR TREATMENT SUCH AS:

- MISSING TOOTH CLAUSE
- PROCEDURES WHICH ARE NOT A BENEFIT
- INACCURATE INFORMATION RECEIVED FROM THE PATIENT
- ANNUAL BENEFIT MAXIMUM BEING REACHED
- CHANGES OR TERMINATION OF COVERAGE

FEES RESULTING FROM LIMITS AND EXCLUSIONS ARE THE PATIENT'S RESPONSIBILITY.

INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL INFORM YOU IF WE ARE PARTICIPATING WITH YOUR INSURANCE PLAN AND WILL HANDLE YOUR CLAIM ACCORDING TO OUR AGREEMENT WITH THE INSURANCE COMPANY. WE FILE INSURANCE CLAIMS AS A COURTESY TO YOU, OUR PATIENT. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED AND NON-COVERED CHARGES, SECONDARY INSURANCES, "USUAL AND CUSTOMARY" CHARGES, ETC., OTHER THAN TO SUPPLY NECESSARY FACTUAL INFORMATION. DEDUCTIBLES AND/OR CO-PAYMENTS ARE REQUIRED TO BE PAID BY YOU AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR THE PROMPT PAYMENT OF YOUR ACCOUNT. IF PAYMENT IS NOT RECEIVED FROM YOUR INSURANCE COMPANY BY US WITHIN 90 DAYS, THE BALANCE OF THE ACCOUNT BECOMES YOUR RESPONSIBILITY. I HEREBY AUTHORIZE AND AGREE AS FOLLOWS:

- I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I UNDERSTAND I AM RESPONSIBLE FOR MY ACCOUNT.
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
- I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- I UNDERSTAND BENEFIT INFORMATION GIVEN TO ME BY MY DOCTOR OR THEIR STAFF IS NOT A GUARANTEE OF PAYMENT.
- I UNDERSTAND THAT PAYMENT OF MY ACCOUNT MUST BE RECEIVED WITHIN 90 DAYS OF DATE OF SERVICE, REGARDLESS OF MY INSURANCE.

I HAVE READ THE ABOVE FINANCIAL POLICY AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE PAID BY MY INSURANCE. I UNDERSTAND THAT IF MY ACCOUNT IS NOT PAID WITHIN 90 DAYS, IT WILL BE TURNED OVER TO THE CREDIT BUREAU FOR COLLECTION AND A 30% COLLECTION FEE WILL BE ADDED.

_____ _____

SIGNATURE *DATE*

PATIENT NAME: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME	**EMAIL ADDRESS**	**ADDRESS**
_____	_____	_____
SOCIAL SECURITY NUMBER	**PHONE NUMBER**	_____
_____	_____	_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME.

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEATH CARE OPERATIONS.

_____ _____

SIGNATURE *DATE*