



Patient Information

Gender

Male Female

Title

None Mr. Mrs. Miss. Ms. Dr.

Date

M D Y

First Name

MI

Last Name

Preferred Name

Birthdate

Social Security #

M D Y

Cell

Home

Work

Ext

Address

City

State

Zip Code

Email

How did you learn of our office?

Marital Status

Married Single Child Other

Appointment Preference

On Short Notice?

Time to call

None AM PM

Yes No

For your convenience our office can communicate with you by text or email. It's okay for the office to

Text me Email me Send me appointment reminders

Patient Is (Select All That Apply)

Patient Policy Holder Responsible Party

Patient Information

Employed

Full-Time Part-Time N/A

Student

Full-Time Part-Time N/A

Please fill in further details related to student details

School Name

Address

City

State

Zip Code

In case of emergency, please contact

Text

Phone

Relation

Who is responsible for your account?

Self Spouse Father Mother Other

Please fill in further details related to your Spouse/Father/Mother details

Resp. First

Resp. Last

Responsible Date Of Birth

M D Y

Resp. Phone

Address

City

State

Zip Code

Responsible Social Security #

Responsible Employer

Insurance Information

Do you have Insurance?

Yes No

Type Of Insurance

Dental Medical

Type Of Insurance

Please fill in further details related to your insurance

Insurance Company Name

I.D. #

Address

City

State

Zip Code

Group #

Group Name

Patient Information

Relation If Other Policy Holder First Name Policy Holder Last Name

Insured Birthdate Social Sec. # Phone
M D Y

Address City

State Zip Code

Do You Have Secondary Insurance? Yes No Secondary Type Dental Medical Employer For Secondary

Please fill in further details related to your secondary insurance

Secondary Ins. Company Name Secondary Ins. I.D. #

Address City

State Zip Code

Secondary Ins. Group # Secondary Ins. Group Name

Relation2

Dental Information

Reason for today's visit

Are you in pain?

Yes No

For how long?

Patient Information

Please indicate any of the following problems by selecting the corresponding box:

| | | | | | |
|---|--------------------------|--|--------------------------|------------------------------|--------------------------|
| Discomfort, clicking, or popping in jaw | <input type="checkbox"/> | Lost / broken filling(s) | <input type="checkbox"/> | Stained teeth | <input type="checkbox"/> |
| Difficulty closing jaw | <input type="checkbox"/> | Red, swollen, or bleeding gums | <input type="checkbox"/> | Teeth grinding / clenching | <input type="checkbox"/> |
| Locking jaw | <input type="checkbox"/> | Difficulty opening jaw | <input type="checkbox"/> | A removable dental appliance | <input type="checkbox"/> |
| ringing in ears | <input type="checkbox"/> | Bad breath | <input type="checkbox"/> | Loose / shifting teeth | <input type="checkbox"/> |
| Blisters / sores in or around the mouth | <input type="checkbox"/> | Broken / chipped tooth | <input type="checkbox"/> | Burning tongue / lips | <input type="checkbox"/> |
| Gum Disease | <input type="checkbox"/> | Prolonged bleeding from an injury / extraction | <input type="checkbox"/> | Toothache | <input type="checkbox"/> |
| Swelling / lumps in mouth | <input type="checkbox"/> | Recent infections or sore throat | <input type="checkbox"/> | Food caught between teeth | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | If other, please explain | | | |

My teeth are sensitive to:

Hot Cold Sweets Biting

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date

M D Y

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

Signature

Date

M D Y

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Date M D Y

First Name

Last Name

Birthdate

M D Y

Are you under the care of a physician? Yes No

Have you ever been hospitalized or had a major operation? Yes No

Are you taking any medications, pills or drugs? Yes No

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? Yes No

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 Sulfa Drugs Local Anesthetic

Do you have any other known allergies?

Yes No

Do you have or have you had any of the following diseases or medical conditions?

No to all

AIDS/HIV Positive Hemophilia Alzhei-mer's Disease Hepatitis A

Cortisone Medicine Radiation Treatments Diabetes Recent Weight Loss

Anaphy-laxis Drug Addiction Hepatitis B or C Renal Dialysis

| | | | |
|--|--|--|---|
| Anemia <input type="checkbox"/> | Easily Winded <input type="checkbox"/> | Herpes <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Emphy-sema <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Rheu-matism <input type="checkbox"/> |
| Arthritis Gout <input type="checkbox"/> | Epilepsy or Seizures <input type="checkbox"/> | High Choleste-rol <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Artificial Heart Valve <input type="checkbox"/> | Excessive Bleeding <input type="checkbox"/> | Hives or Rash <input type="checkbox"/> | Shingles <input type="checkbox"/> |
| Artificial Joint <input type="checkbox"/> | Excessive Thirst <input type="checkbox"/> | Hypo-glycemia <input type="checkbox"/> | Sickle Cell Disease <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Fainting Spells/Dizziness <input type="checkbox"/> | Irregular Heartbeat <input type="checkbox"/> | Sinus Trouble <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Frequent Cough <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> | Spina Bifida <input type="checkbox"/> |
| Blood Trans-fusion <input type="checkbox"/> | Frequent Diarrhea <input type="checkbox"/> | Leukemia <input type="checkbox"/> | Stomach / Intestinal Disease <input type="checkbox"/> |
| Breathing Problem <input type="checkbox"/> | Frequent Headaches <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Bruise Easily <input type="checkbox"/> | Genital Herpes <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Swelling of Limbs <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Lung Disease <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> |
| Chemo-therapy <input type="checkbox"/> | Hay Fever <input type="checkbox"/> | Mitral Valve Prolapse <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Chest Pains <input type="checkbox"/> | Heart Attack/Failure <input type="checkbox"/> | Osteop-rosis <input type="checkbox"/> | Tuber-culosis <input type="checkbox"/> |
| Cold Sores/Fever Blisters <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Pain in Jaw Joints <input type="checkbox"/> | Tumors or Growths <input type="checkbox"/> |
| Congenital Heart Disorder <input type="checkbox"/> | Heart Pacemaker <input type="checkbox"/> | Parathy-roid Disease <input type="checkbox"/> | Ulcers <input type="checkbox"/> |
| Convul-sions <input type="checkbox"/> | Heart Trouble/Disease <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Yellow Jaundice <input type="checkbox"/> | | | |

Have you ever had any serious illness not listed above?

Yes No

If yes please explain

Comments

Text

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature (Patient or Guardian)

Date

M D Y



HIPAA Notice of Privacy Practices

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
 - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
-

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
 - We may not be able to grant your request, but we'll tell you why in writing within 60 days.
-

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
 - We will say “yes” to all reasonable requests.
-

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care. “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say “yes” unless a law requires us to share that information

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
-

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
-

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
 - We will make sure the person has this authority and can act for you before we take any action.
-

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the top of the page
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
 - We will not retaliate against you for filing a complaint.
-

Your Choices

- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
-

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety

In these cases we never share your information unless you give us written permission:

- Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
-

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
-

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: _____

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The clinic will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

First Name

Last Name

Last

Patient or Legal Guardian Signature

Date

M D Y

Office Policies

Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require advanced notice when changing or cancelling an appointment.

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us with advanced notice. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once may result in a charge.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice and asked to find another dentist.

Any patient who is late may be considered a "no show" for their appointment and may need to be rescheduled.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above appointment policy.

First Name

Last Name

Patient or Legal Guardian Signature

Date

M D Y