

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: Child
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Alt.): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F
Email address: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Developmentally Delayed |
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Growths | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Autistic | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |

- List any medication(s) that the patient is currently taking: _____

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

- Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Internet School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's parent(s) and or legal guardian the person responsible for payment

Name (Father): _____
 Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Name (Mother): _____
 Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

Employer Name (Father): _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Employer Name (Mother): _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. **Therefore, payment is due on the date that services are rendered.**

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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. **If insurance does not pay expected amount, the patient will be held responsible for any outstanding balance on their account. Any account 90 days past due will be sent to an attorney and or collections agency. In this event, the patient will be held responsible for any fees associated with the collection.**

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered by the Doctor to me, my spouse or my child, or at my request, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees should any account due from me be referred to an attorney for collection.

I understand that at least 24 hours notice is required when cancelling any scheduled appointment. Failure to do so, after the 1st no show, will result in dismissal from this office as an active patient. Emergency care will however be provided as a courtesy for 30 days following inactivation.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



HIPAA - Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have to the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following: a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians and or dentists) b) Obtaining payment from third party payers (i.e. my insurance company) c) The day-to-day healthcare operations of your practice

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____

Parent/Guardian

Signature

Date

Compliance Assurance Notification for Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosures of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of that fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Patient

Date

Staff

