Patient Information Form

Name _____ Date of Birth _____ Male/Female

Street _____

City _____ State _____ Zip _____

Cell Phone _____ Secondary Phone (home/work) _____

Email Address _____

Social Security Number (used for insurance purposes) _____

Employer Name _____

Emergency Contact _____ Phone_____ Relationship to Patient _____

Preferred Method of Contact for Appointment Reminders (circle)

Text Call/Voicemail Email Postcard

Please Check Whichever Applies

- ☐ Primary Dental Insurance Only
- ☐ Primary Dental Insurance & Secondary Dental Insurance
- ☐ No dental insurance

Patient / Parent or Guardian's Signature _____ Date _____

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Patient Medical History Form

Patient's Full Name:_____

Phone: (Home)_____ (Cell)_____ (Work)_____

Address:_____

City:_____ Zip:_____ Birthdate:_____

Gender: Male / Female Occupation:_____

Reason for dental visit today:_____

Are you currently under the care of a doctor? Yes / No If yes, why?_____

Medical Doctor's Name:_____ City:_____

Phone:_____ Date of last medical visit:_____ Reason:_____

Medications:_____

_____

☐ Medication list attached

Please **CHECK** (Yes/No) if **YOU** have or ever had any of the following:

YES / NO

- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Heart Disease/Defects/Surgery/Stents
- ☐ ☐ Heart Attack
- ☐ ☐ Stroke
- ☐ ☐ Cancer
- ☐ ☐ Radiation Therapy When:_____
- ☐ ☐ Chemotherapy When:_____
- ☐ ☐ Bone-loss Drugs (eg. Fosamax, Zometa)
- ☐ ☐ History of Osteoporosis
- ☐ ☐ Lung Disease/Shortness of Breath
- ☐ ☐ Asthma
- ☐ ☐ Liver Disease
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Taking Blood Thinners
- ☐ ☐ HIV/AIDS
- ☐ ☐ Diabetes
- ☐ ☐ Organ Transplant
- ☐ ☐ Kidney Disease/On Dialysis
- ☐ ☐ Intellectual Disability
- ☐ ☐ Alzheimer's/Dementia
- ☐ ☐ Epilepsy/Seizures
- ☐ ☐ Sleep Apnea

YES / NO

- ☐ ☐ Artificial Joint
  Location of Joint:_____
  When was it placed:_____
- ☐ ☐ Take Antibiotics Before Dental Work
  Reason:_____
- ☐ ☐ Allergies to Drugs/Medications
  Which ones:_____
- ☐ ☐ Other Allergies:_____

_____

- ☐ ☐ Tobacco Use / Packs Per Day?_____
- ☐ ☐ Alcohol Use
- ☐ ☐ Recreational Drug Use
- ☐ ☐ Cocaine Use

Females:

- ☐ ☐ Are You Pregnant? Due Date:_____
- ☐ ☐ Taking Birth Control?

**I certify that the information provided on this form is correct to the best of my knowledge.

_____

Patient / Parent or Guardian's Signature

_____

For The Office to Complete

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Financial Policy

Patients with Dental Insurance

We are happy to file the necessary forms to help you receive the full benefits of your insurance; however, **we make no guarantee of any estimated coverage or payment**. Because insurance is an agreement between you and your insurance company, all patients are responsible for all charges. *Important: we are not a Medicaid certified office. We cannot submit claims to Medicaid and patients with Medicaid are expected to pay their balance, in full, on the day of the service.

****Patient portion is expected in full at time of service.**

Patients without Dental Insurance

Payment is expected in full at time of service.

For established patients without insurance at time of service – payments made by cash, check, HSA, or qualifying debit cards may qualify you for a 5% discount. Not all of our services qualify for this discount (tongue/lip tie releases do not qualify).

Financial Responsibility

For patients under the age of 18, parent/legal guardian who brings in the child is responsible for payment.

For dependents over the age of 18, parent(s) are responsible for payment. If someone is under legal guardianship it is necessary for the guardian to sign forms.

We feel it is important to keep you informed of your treatment costs. At any time, you may request a treatment plan estimate. Please keep in mind certain circumstances may alter treatment or fees.

Any balances not paid in full within 30 days from date of transaction will result in a 1.5% monthly finance charge and/or will be sent to collections. We reserve the right to dismiss any patient for default of payment.

Credit Card

We accept Visa, Mastercard, and Discover credit cards (no 5% discount).

Cancellation Policy

We require a 24-hour notice for cancellations.
Failure to do so will result in a $50 charge and/or patient dismissal.
If patient fails to show for first visit, patient will be automatically dismissed.

Patient / Parent or Guardian's Signature _____ Date _____

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Personal Health Information Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order 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, or 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 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 only interact with physicians 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 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.

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. Please fill out the following information.

List names of who may have access to patient's medical information:

_____ _____

_____ _____

Patient / Parent or Guardian's Signature _____ Date _____

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