



## NOTICE OF PRIVACY POLICIES

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Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**CONSENT FOR TREATMENT:** I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

### YOUR RIGHTS

You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_

SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  Gender Neutral

Home Address: \_\_\_\_\_  
APT./CONDO #:  
\_\_\_\_\_  
CITY STATE ZIP

Cell #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

How do you prefer to be contacted?  E-Mail  Phone  Text

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

How did you find out about us?  Friend  Google  ZocDoc  
 Yelp  Facebook  Other

Whom may we Thank for referring you? \_\_\_\_\_

## INSURANCE COVERAGE

### Primary

Dental Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### Secondary

Dental Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

SS #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Cell: \_\_\_\_\_ Employer: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

## EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: \_\_\_\_\_ Cell #: \_\_\_\_\_

CONTINUED ON BACK

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs?  
 Yes  No

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

**For Women:** Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

Have you ever had any of the following diseases or medical problems?

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding              | <input type="checkbox"/> Hepatitis                    |
| <input type="checkbox"/> Alcohol / Drug Abuse           | <input type="checkbox"/> Herpes / Fever Blisters      |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> HIV+ / AIDS                  |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Hospitalized for Any Reason  |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Kidney Problems              |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Liver Disease                |
| <input type="checkbox"/> Cancer/Chemotherapy            | <input type="checkbox"/> Low Blood Pressure           |
| <input type="checkbox"/> Colitis                        | <input type="checkbox"/> Mitral Valve Prolapse        |
| <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> Pacemaker                    |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Psychiatric Problems         |
| <input type="checkbox"/> Difficulty Breathing           | <input type="checkbox"/> Radiation Treatment          |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Shingles                     |
| <input type="checkbox"/> Frequent Headaches             | <input type="checkbox"/> Sickle Cell Disease / Traits |
| <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Hay Fever                      | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Heart Attack                   | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Tuberculosis (TB)            |
| <input type="checkbox"/> Heart Surgery                  | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Hemophilia                     | <input type="checkbox"/> Venereal Disease             |

Please list any serious medical condition(s) that you have ever had:  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any of the following?

- |   |                                       |                                       |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals       |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Jewelry      | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex        | <input type="checkbox"/> Tetracycline |

Please list any other drugs/materials that you are allergic to:  
\_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

Why have you come to the dentist today?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No Do your gums ever bleed?  Yes  No

Have you ever had a serious / difficult problem associated  
with any previous dental work?  Yes  No

Do you now or have you ever experienced pain /  
discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No

Would you like whiter teeth?  Yes  No Fresher breath?  Yes  No

How many times a week do you floss? \_\_\_\_\_ a day do you brush?

Type of bristles?  Soft  Medium  Hard

Do you smoke or use tobacco in any other form?  Yes  No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Date

Signature

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.



## Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We are a “No Wait” office and do not double book. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

**There is a \$75 charge for not showing up for scheduled appointments or cancellations within 48 hours. Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. You can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I have read and understand the appointment policy

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Name

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Date