Patient Consent Form

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ________________________________

Signature: ___________________________________

Relationship to Patient: _________________________

Date: __________________

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name ____ Soc. Sec. # __________________
Last Name First Initial
Address ____
City ___________________ State _______ Zip ___________ Home Phone __________________
Cell Phone _________________ Email ____
Sex ☐M ☐F Age ______ Birthdate _____________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient Employed by __________________________________ Occupation __________________
Business Address __________________________________ Business Phone _________________
Business Email ____
Whom may we thank for referring you? ____
Notify in case of emergency ___________________________ Home Phone __________________
Cell Phone ____ Business Phone _________________

Primary Insurance

Person responsible for account ____
Last Name First Initial
Relation to Patient ______________ Birthdate ________________ Soc. Sec. # __________________
Address (*if different from patient*) ____
City ___________________ State _______ Zip ___________ Home Phone __________________
Cell Phone _________________ Email ____
Person Responsible Employed by ______________________________ Occupation ______________
Business Address __________________________________ Business Phone _________________
Business Email ____
Insurance Company __________________________________ Phone ______________________
Insurance Email ____
Contract # ________________________ Group # ______________ Subscriber # ______________
Name of other dependents under this plan ____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No
Subscriber Name ___________________________ Relation to Patient _______________________
Relation to Patient ______________ Birthdate ________________ Soc. Sec. # __________________
Address (*if different from patient*) ____
City ___________________ State _______ Zip ___________ Home Phone __________________
Cell Phone _________________ Email ____
Subscriber Employed by __________________________________ Occupation _________________
Business Phone _________________ Business Email ______________________________________
Insurance Company __________________________________ Phone ______________________
Insurance Email ____
Contract # ________________________ Group # ______________ Subscriber # ______________
Name of other dependents under this plan ____

Please complete both sides

Dental History

What would you like us to do today? ________________________ Are you in dental discomfort today? _________
Former Dentist _____________________________ Address ____
Dentist's Email ____ Phone _______________________________
Date of last dental care ______________________________ Date of last x-rays ____________________________
Check (x) yes or no if you have had problems with any of the following:

☐Y☐N	Bad Breath	☐Y☐N	Food collection between teeth	☐Y☐N	Periodontal treatment	☐Y☐N	Sensitivity to sweets
☐Y☐N	Bleeding Gums	☐Y☐N	Grinding or clenching teeth	☐Y☐N	Sensitivity to cold	☐Y☐N	Sensitivity when biting
☐Y☐N	Clicking or popping jaw	☐Y☐N	Loose teeth or broken fillings	☐Y☐N	Sensitivity to hot	☐Y☐N	Sores or growths in mouth

How often do you brush? ___________________________________ Floss? ______________________________
How do you feel about the appearance of your teeth? ____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?☐Y☐N
Other information about your dental health or previous treatment ____

Medical History

Physician's Name ____ Phone ____________________________

Date of last visit ___________________ Have you had any serious illnesses or operations? ☐Y☐N
If yes, describe ____

Are you currently under physician care? ☐Y☐N If yes, describe _____________________________________

Have you ever had a blood transfusion? ☐Y☐N If yes, give approximate dates _________________________

Have you ever taken Fen-Phen/Redux? ☐Y☐N

Women: Are you pregnant? ☐Y☐N Nursing ☐Y☐N Taking birth control pills? ☐Y☐N
Check (x) yes or no if you have had problems with any of the following:

☐Y☐N	AIDS/HIV Positive	☐Y☐N	Cough, persistent	☐Y☐N	Jaw pain	☐Y☐N	Spina Bifida
☐Y☐N	Anaphylaxis	☐Y☐N	Cough up blood	☐Y☐N	Kidney disease or malfunction	☐Y☐N	Stroke
☐Y☐N	Anemia	☐Y☐N	Diabetes	☐Y☐N	Liver disease	☐Y☐N	Surgical implant
☐Y☐N	Arthritis, Rheumatism	☐Y☐N	Epilepsy	☐Y☐N	Material allergies (**latex**, wool, metal, chemicals)	☐Y☐N	Swelling of feet or ankles.
☐Y☐N	Artificial heart valves	☐Y☐N	Fainting	☐Y☐N	Mitral valve prolapse	☐Y☐N	Thyroid disease or malfunction
☐Y☐N	Artificial joinyd	☐Y☐N	Food allergies	☐Y☐N	Nervous problems	☐Y☐N	Tobacco habit
☐Y☐N	Asthma	☐Y☐N	Glaucoma	☐Y☐N	Pacemaker / Heart surgery	☐Y☐N	Tonsillitis
☐Y☐N	Atopic (allergy prone)	☐Y☐N	Headaches	☐Y☐N	Psychiatric care	☐Y☐N	Tuberculosis
☐Y☐N	Back problems	☐Y☐N	Heart murmur	☐Y☐N	Rapid weight gain or loss	☐Y☐N	Ulcer/Colitis
☐Y☐N	Blood disease	☐Y☐N	Heart problems	☐Y☐N	Radiation treatment	☐Y☐N	Venereal disease
☐Y☐N	Cancer	Describe: _________________		☐Y☐N	Respiratory disease		
☐Y☐N	Chemical dependency	☐Y☐N	Hemophilia / Abnormal bleeding	☐Y☐N	Rheumatic/Scarlet fever		
☐Y☐N	Chemotherapy	☐Y☐N	Herpes	☐Y☐N	Shingles		
☐Y☐N	Circulatory problems	☐Y☐N	Hepatitis	☐Y☐N	Shortness of breath		
☐Y☐N	Cortisone treatments	☐Y☐N	High blood pressure	☐Y☐N	Skin rash		

Is patiently currently taking medications? If yes, list all:
____
____

Does patient have drug allergies? If yes, list all:
____
____

Authorization

I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ____ Date: ________________________

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