Patient Information

Patient Information

Preferred Name	Gender	Date of Birth	Marital Status
Social Security #	Primary Phone	Secondary Phone	Email
Home Address	City	State	Zip Code
Student Status	Best time to contact you	Send appointment reminders via	Please tell us where you heard about us
If friend, relative, or other, please state here			
Other family members treated by us			

Employment Information

Are you currently employed?

Employment	Employer's Name	Employer's Phone	Occupation
Employer Address	City	State	Zip Code

Emergency Contact

This is typically the nearest relative who does not live with the patient

Name	Relationship to Patient	Primary Phone	Email Address

Insurance Information

Person Responsible for Account

Is the person responsible for the account different than the patient?

First Name	Last Name	Relationship to Patient	Date of Birth
Phone	Email Address	Billing Address	City
State		Zip Code	

Employment Information of Person Responsible for Account

Is the employment information of the person responsible for the account different than the employment information of the patient?

Employment	Employer's Name	Employer's Phone	Occupation
Employer Address	City	State	Zip Code

Primary Insurance

Does the patient have insurance?

Insurance Holder's Name	Date of Birth	Relationship to Patient	Employer
Member ID	Group ID	Insurance Company Name	Insurance Company Phone
Insured's SSN	Insurance Company's Address	City	State
Zip Code			

Secondary Insurance

Does the patient have secondary insurance?

Insurance Holder's Name	Date of Birth	Relationship to Patient	Employer
Member ID	Group ID	Insurance Company Name	Insurance Company Phone
Insured's SSN	Insurance Company's Address	City	State
Zip Code			

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize the dentist and staff to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to the dentist and staff. I permit a copy of this authorization to be used in place of the original. I give the dentist, staff, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically)

Date

Treatment Consent

Consent for Treatment

Patient Name

**I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.**

Signature (Type your name to sign electronically, or print and sign)

Date

Payment Policies

Payment

Does the person responsible for the account already have an account with this office?

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance.

Please choose a method of payment below.

If Credit Card is your preferred method, please fill out the following information:

Type (VISA, MC, Discover, AmEx, etc.)	Credit Card Number	Expiration	Card Verification Code (VISA/MC/Discover: 3-digit code printed on back. AmEx: 4-digit code printed on front)

Your credit card information is kept on file for outstanding account balances

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our staff members for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments with the understanding that any uninsured portion that is not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

*** Personal checks that are returned due to 'insufficient funds'are subject to a $25.00 service fee.**

Minors

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

I hereby authorize payment directly to this practice of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment for the patient named below. The information on the page and the dental / medical histories are correct to the best of my knowledge. I grant the right to this practice to release the patient's dental and / or medical histories and other information about the patient's dental treatment to third-party payers and / or other health professionals.

Signature (Type your name to sign electronically)

Date	Patient Name

Dental History

Last Dental Visit

Have you been to the dentist before?

Last Dental Visit	What was done at your last dental visit?	Approximate Date of Last X-Rays	Approximate Date of Last Full-Mouth X-Rays
Approximate Date of Last Cleaning			

Teeth

Do you have any of the following?

Bad taste in mouth	Blisters on lips/mouth	Broken or chipped	Crooked teeth
Tooth decay	Difficulty chewing	Discolored teeth	Loose/missing filling
Loose teeth	Tooth pain	Food trap areas	Grinding or clenching
Missing teeth	Mouth sores	Orthodontic treatment	Sensitive to temperature
Sensitive when biting	Sensitive to sweets		

Facial/Jaw Pain

In regard to facial/jaw pain, do you

Have frequent headaches	Avoid certain foods	Experience popping/clicking	Have pain in temples
Have times when your jaw locks open/closed	Have pain in jaw	Currently have a jaw injury	Currently have a head injury
Currently have a neck injury	Currently have pain around ear		

Orthodontic

Have you ever had orthodontic treatment?

Do you have/have you had any of the following?

Night Guard	Oral Surgery	Periodontal Treatment	Your bite adjusted
Any canker sores or cold sores on your lips, tongue, gums, or body	Smile makeover	Cosmetics	Retainer
Teeth straightening	Teeth straightening		
Please explain			

Other

Do you have/have you had any of the following?

A history of smoking/dipping	A history of biting cheeks or lip	Tooth-colored fillings	Burning tongue
Wisdom teeth	Tooth replacement	Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth?	Fractured tooth syndrome
Dental phobias	A habit of nail-biting		
Comments			

Sleep/Airway Issues

Do you have any sleep/airway issues?

Does the patient tend to be a mouth breather	Does the patient snore at night	Does the patient seem rested in the morning	Is the patient often sleepy during the day
Has the patient seen an ear, nose or throat specialist	Is the patient using a sleep apnea device	Prior TMJ treatment	CPAP
Comments			

Medical History

Medical Background

Are you currently under medical treatment?	**Do you require antibiotic pre-medication for your dental work?**	**Physician's Name**	**Phone**
Last visit			**Do we have permission to contact your doctor regarding your care?**

Medical History

Do you currently have or have a history of any of the following?

Acid Reflux	**ADHD/ADD**	**AIDS/HIV**	**Anemia**
Arthritis	**Asthma**	**Autism**	**Bone Disorders**
Cancer	**Cerebral Palsy**	**Chest Pain**	**Chronic Neck Pain**
Cold Sores/Herpes	**Diabetes**	**Down Syndrome**	**Ear Pain**
Endocrine Problems	**Emotional Disorders**	**Epilepsy**	**Headaches**
Heart Condition	**Hepatitis**	**Immune Problems**	**Kidney Problems**
Low Blood Pressure	**Muscular Disorders**	**Nervous Disorders**	**Organ Transplant**
Osteoporosis	**Prolonged Bleeding**	**Rheumatic Fever**	**Scoliosis**
Seizures	**Sinus Problems**	**Tuberculosis**	

Comments

Certification

All of the above information is correct to the best of my knowledge. I understand that providing incorrect\ninformation can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of\nany changes in medical status. I understand that the above information is necessary to provide me with\ndental care in an efficient and safe manner. Should further information be needed, you have my permission\nto ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign)

Date

HIPAA

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.\n\nAs required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.\n\nWe may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:\n\n* Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.\n\n* Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.\n\n* Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.\n\n* To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.\n\nIn some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:\n\n* When a state or federal law mandates that certain health information be reported for a specific\npurpose\n\n* For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices\n\n* Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence\n\n* Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws\n\n* Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies\n\n* Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else\n\n* Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations Uses or disclosures for health-related research\n\n* Uses or disclosures for health-related research\n\n* Uses and disclosures to prevent a serious threat to health or safety\n\n* Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service\n\n* Disclosures of de-identified information\n\n* Disclosures relating to worker's compensation programs\n\n* Disclosures of a 'limited data set' for research, public health, or healthcare operations\n\n* Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures\n\n* Disclosures to 'business associations' who perform healthcare operations for our office and who commit to respect the privacy of your health information\n\nWe may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.\n\nYou have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:\n\nThe right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove\nit.\n\n* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.\n\n* The right to inspect and copy your protected health information.\n\n* The right to amend your protected health information.\n\n* The right to receive an accounting of disclosures of protected health information.\n\nWe are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.\n\nThis notice is effective as of September 5, 2019, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.\n\nWe reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.\n\nIf you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.\n\nFor more information about HIPAA and/or to file a complaint, please call or visit or office or contact:\n\nThe U.S. Department of Health & Human Services, Office for Civil Rights\n200 Independence Avenue, S.W.\nWashington D.C. 20201\n(202) 619-0257 Toll Free: 1-877-696-6775

Patient Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent of Use of Health Information

The undersigned does hereby acknowledge that they have received a copy of this office's Notice of Privacy Practices pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance leaflet is available upon request. The undersigned does hereby consent to the use of their health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA, the HIPAA Compliance leaflet, State law and Federal law.

If the undersigned is a parent or guardian of the patient, they do acknowledge and consent to the above paragraph on behalf of the patient.

Date	Patient Name
Patient/Parent/Guardian Signature	

For more information, contact:\nThe U.S. Department of Health & Human Services\nOffice of Civil Rights\n200 Independence Avenue, S.W.\nWashington, D.C. 20201\n(877) 696-6775 (toll-free)