PATIENT'S NAME_____

Last First Initial Date of Birth

Please comment on all yes answers in the space below.

CIRCLE THE APPROPRIATE ANSWER

1. Reason for today's visit:_____
2. How long since your last dental visit? _____
3. What was done at that time? _____
4. Was there any recommended dental treatment not completed? YES NO
5. Were dental x-rays taken? YES NO
6. When was the last time your teeth were cleaned? _____
7. Previous dentist's name _____

   Address _____

   _____ Phone _____
8. Have any of your teeth been lost or removed? YES NO
9. If yes, have they been replaced? YES NO
10. Do you clench or grind your teeth? YES NO
11. Are your teeth sensitive to: hot ___ cold ___ sweets ___ pressure ___
12. Does your jaw click or pop? YES NO
13. Do you have frequent head, neck, or shoulder aches? YES NO
14. Have you had any orthodontic treatment? YES NO
15. Does food frequently get caught between your teeth? YES NO
16. Do your gums bleed or hurt? YES NO
17. Are any of your teeth loose, tipped or shifted? YES NO
18. Do you feel your breath is routinely offensive? YES NO
19. Have you ever had gum treatment or surgery? YES NO

    If yes, what was done and when? _____
20. How often and when do you brush your teeth? YES NO
21. Do you use dental floss? YES NO
22. How do you feel about your teeth in general? YES NO
23. Have you had any unpleasant dental experiences or is there anything we have not covered in this form? YES NO
24. Is there anything else we should know about your health that we have not covered in this form? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY

PATIENT'S NAME_____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER **COMMENTS** (Include date, details, initials)

1. When was your last complete physical exam?_____ (Date)
2. Are you under a physician's care?.....YES NO
3. Are you taking any medications?.....YES NO
4. Do you have any allergies?.....YES NO
5. Are you allergic to any medications or substances?.....YES NO
6. Are you pregnant or suspect you might be pregnant?.....YES NO
7. Do you use birth control medications?.....YES NO
8. Do you have heart disease?.....YES NO
9. Have you ever had rheumatic fever?.....YES NO
10. Are you aware of any heart murmurs?.....YES NO
11. Do you have a pacemaker or an artificial valve implant?.....YES NO
12. Do you have high blood pressure?.....YES NO
13. Do you have low blood pressure?.....YES NO
14. Do you have any blood disorders?.....YES NO
15. Have you ever bled excessively?.....YES NO
16. Do you have any stomach or intestinal problems?.....YES NO
17. Do you have any liver problems?.....YES NO
18. Do you consume alcoholic beverages?.....YES NO
19. Have you ever tested positive for hepatitis?.....YES NO
20. Do you have any kidney problems?.....YES NO
21. Have you ever had a venereal disease?.....YES NO
22. Have you ever tested HIV positive?.....YES NO
23. Do you have any history of respiratory problems?.....YES NO
24. Do you have asthma?.....YES NO
25. Do you have or have you ever had TB?.....YES NO
26. Do you smoke, chew, or use other forms of tobacco?.....YES NO
27. Do you have any hormonal problems?.....YES NO
28. Are you a diabetic?.....YES NO
29. Do you have low blood sugar?.....YES NO
30. Do you have any inflammatory diseases: arthritis, rheumatism?.....YES NO
31. Do you have any artificial joints/prosthesis?.....YES NO
32. Have you ever had a major surgery?.....YES NO
33. Do you have any complications with any forms of anesthesia?.....YES NO
34. Have you ever had radiation treatment or chemotherapy?.....YES NO
35. Have you ever had psychiatric or psychological treatment?.....YES NO
36. Do you habitually use controlled substances?.....YES NO
37. Do you have any disease, condition, or problem not listed?.....YES NO
38. Is there anything else we should know about your health that we have not covered on this form?.....YES NO

Revision date_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

Vital Signs

Physical Description of Patient

Nutritional Assessment

Subjective Description of Patient

MEDICAL HISTORY

PATIENT INFORMATION
(Person being seen for visit)

NAME_____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED_____

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #_____Date of Birth_____ Age_____

ADDRESS—STREET_____

CITY_____STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____ Drivers Lic.#_____

BEST TIME TO CALL_____EMAIL_____

GUARANTOR INFORMATION
(Person responsible for the account)

NAME_____
Last First Initial

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #_____Date of Birth_____ Age_____

ADDRESS—STREET_____

CITY_____STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____ Drivers Lic.#_____

BEST TIME TO CALL_____EMAIL_____

EMPLOYMENT INFORMATION FOR GUARANTOR

NAME OF EMPLOYER_____ADDRESS_____

CITY_____STATE____ZIP_____PHONE_____FAX_____

REGISTRATION

EMERGENCY INFORMATION
(Someone to notify in case of emergency)

NAME_____

ADDRESS_____

PHONE: HOME_____WORK_____CELL_____

REFERRAL INFORMATION
(Whom may we thank for this referral)

NAME_____ADDRESS_____

____yellow pages ____benefits manager ____insurance co. ____direct mail ____internet

Other_____

PRIMARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE_____

ADDRESS TO SEND CLAIMS (if applicable) _____

CITY_____STATE_____ZIP_____PHONE_____

NAME OF INSURED SUBSCRIBER_____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____INSURED'S SS# OR ID#_____

SECONDARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE_____

ADDRESS TO SEND CLAIMS (if applicable) _____

CITY_____STATE_____ZIP_____PHONE_____

NAME OF INSURED SUBSCRIBER_____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____INSURED'S SS# OR ID#_____

REGISTRATION

RELEASE

1. I authorize the dentist to perform diagnostic procedures and treatment as may be deemed necessary for proper dental care.
2. I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.
3. I authorize the dental group and/or its agents to transmit patient billing and/or insurance information to my insurance carrier electronic communication address in lieu of U.S. Postal Service.
4. I authorize the dental group to communicate through the use of electronic mail; appointment reminders, bills and other financial information, unfinished treatment plans which may contain information related to health issues identified by my dentist during previous appointments, and any other necessary information related to my dental treatment that my dentist believes necessary. I am providing the e-mail address listed below for that purpose. I understand that it is my responsibility to notify my dentist when my e-mail address changes as soon as is practical. I understand that e-mail is being used for my convenience and privacy and improved efficiency in communicating with my dentist. I will not hold the dentist responsible for disclosures that occur due to other individuals reading e-mails sent to the address provided below
5. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
6. I understand that I am financially responsible for payments in full of my dental account.
7. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part, by my dental plan payer.

_____ _____

Patient's or Guardian's Signature Date

SIGNATURE ON FILE

Dental Health Centers is authorized to provide any insurance company, administrator, and consulting health care professional, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract in force on this date only. I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient's or Guardian's Signature

I hereby authorize payment directly to Dental Health Centers of the dental benefits otherwise payable to me.

Insured's Signature

SPECIFIC CHARGES THAT APPLY TO YOU

CLEANINGS
Not All Cleanings Are Free

Cleanings that are covered 100% under your dental plan are routine/simple cleanings only. "Routine" means above the gum line. Patients who have tartar, plaque, or buildup under the gum line require a different, more involved cleaning procedure. There is a completely different billing code and charge for these types of cleanings and your dental plan may or may not cover it. Most patients who have not been examined by the dentist for more than six months require more than a routine cleaning. It is not appropriate for us to perform a routine cleaning and leave the debris under the gums. Professional treatment standards require your dental hygienist or dentist to clean properly under the gum line in order to restore your dental health. We encourage you to ask your hygienist or doctor after your complete examination which type of dental cleaning will be necessary to address your dental care.

WE ARE A MERCURY-FREE OFFICE

We believe that mercury is a toxic substance that should not be put in your mouth. Therefore, we do not do amalgam fillings that contain mercury. Our fillings are made of composite, mercury-free materials. Some insurance companies will only partially cover composite fillings in posterior teeth. We strongly believe that keeping your body free from toxic materials like mercury is worth the small difference in your co-pay for composite fillings.

I have read and understand the specific charges that apply to me as outlined above.

_____ _____

Signature of Patient or Responsible Party *Date*

OUR FINANCIAL POLICY

We want to avoid any misunderstanding about our financial policy as it relates to your responsibility for your account. Please read the following information and be sure to address our staff with any questions you may have.

- If you have dental insurance we will be glad to help you obtain the appropriate benefit from your insurance carrier and bill you carrier as a courtesy to you. However, you are responsible for the payment of your account. We accept cash, check, money order, and credit cards (Visa & MasterCard only).

- Portions of your bill might not be paid by the insurance carrier and must be paid by you. Any insurance deductible or co-payment required by your insurance carrier is due at the time services are rendered.

- If you do not have insurance coverage or if you have a managed care or discount plan, payment is due at the time services are rendered unless other arrangements have been made prior to your appointment.

-If your treatment plan requires a high out-of-pocket expense to you, our office manager can assist you in arranging financing or a payment schedule.

-**If you fail to keep your scheduled appointment** or cancel your appointment without 24 hours notice, your account will be charged a $40.00 broken-appointment charge.

ADDITIONAL TERMS

- **Balances unpaid after 30 days from the date of billing** are subject to a finance charge at the rate of 1 ½ % per month (18% per annum)

- Accounts referred to collections will have collection costs added in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

Thank you for taking the time to familiarize yourself with our financial policy.

Patient or Responsible Party:

I acknowledge that I have read the above information and have had the opportunity to ask questions about its content. I accept full financial obligation for the services that I agree to receive as recommended by the dental professionals at this office.

Name of Patient or Responsible Party_____ Date: _____

Signature of Patient or Responsible Party_____

PATIENT HIPAA CONSENT FORM

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 disclose and use protected health information to carry out:

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

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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 healthcare operations, but that you are not required to agree to these 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 this date I revoked this consent, is not in effect.

Signed this date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: _____

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ❑ Individual Refused to Sign
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____
_____