INSURANCE

Dental Coverage? ❑ Yes ❑ No

Insurance Company Name:_____

Insurance Company Phone #: (____)_____

Subscriber Name:_____ Subscriber DOB: / /

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

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying co-payment and deductibles that the insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including all diagnosis and records of treatment or examination rendered to my insurance company.

Signature_____ Date_____

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat if you choose to refuse to disclose your Personal Health Information (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.

Person Giving Consent

I had the opportunity to read and consider the consents of this form and notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also acknowledge that I received a copy of the notice of Privacy Practices.

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.

Signature_____ Date_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name_____

Phone #: (____)_____ Date of last visit:_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Please explain:_____

Are you taking any blood thinner? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one:_____

_____

Are you taking any osteoporosis medication? ❑ Yes ❑ No

Are you taking any birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:_____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following medical problems?

❑ Y ❑ N Abnormal Bleeding/Hemophilia	❑ Y ❑ N High Blood Pressure
❑ Y ❑ N AIDS / HIV	❑ Y ❑ N Liver Disease
❑ Y ❑ N Alcohol/Drug Abuse	❑ Y ❑ N Low Blood Pressure
❑ Y ❑ N Artificial bones / Joints / Valves	❑ Y ❑ N Mitral Valve Prolapse
❑ Y ❑ N Asthma	❑ Y ❑ N Pacemaker
❑ Y ❑ N Cancer / Chemotherapy	❑ Y ❑ N Psychiatric Problems
❑ Y ❑ N Congenital Heart Defect	❑ Y ❑ N Radiation Treatment
❑ Y ❑ N Diabetes	❑ Y ❑ N Rheumatic/Scarlet Fever
❑ Y ❑ N Epilepsy	❑ Y ❑ N Seizures
❑ Y ❑ N Heart Attack / Heart Surgery	❑ Y ❑ N Sinus Problems
❑ Y ❑ N Heart Murmur	❑ Y ❑ N Stroke
❑ Y ❑ N Hepatitis	❑ Y ❑ N Tuberculosis
❑ Y ❑ N Herpes / Fever Blisters	❑ Y ❑ N Veneral Disease

Please list any serious medical or dental conditions(s) that you have ever had:

_____

Are you allergic to any of the following?

❑ Yes ❑ No Codeine	❑ Yes ❑ No Latex
❑ Yes ❑ No Dental Anesthetics	❑ Yes ❑ No Penicillin
❑ Yes ❑ No Erythromycin	❑ Yes ❑ No Tetracycline

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

_____

Do you require antibiotic/pre-medication before dental treatment? ❑ Yes ❑ No

When was your last dental exam and cleaning? Date:_____

Oral Habits?_____

How would you like to improve your smile?_____

_____