Welcome

The benefits of a healthy smile are immeasurable.
Our goal is to help you reach and maintain maximum oral health.
Please complete the following interview completely so that we may
serve your needs and give you the best of care.

Patient's Name _____Date of Birth ___/___/___ Occupation_____SS#_____

Spouse/Parent Name _____Date of Birth ___/___/___ Occupation_____SS#_____

Patient's Address _____ City_____ State _____ Zip _____

Patient's Home Phone (___)_____ Work# (___)_____ Cell (___)_____

How did you hear about our office? _____

Reason For Today's Visit _____

Primary Dental Insurance

Insurance Co. Name _____Phone #(___)_____Group#_____ ID#_____

Insurance Address_____

Employer's Name _____Address_____ Phone #(___)_____

Insured's Name _____ Date of Birth ___/___/___ SS# _____

Insured's Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance

Insurance Co. Name _____Phone #(___)_____Group#_____ ID#_____

Insurance Address_____

Employer's Name _____ Address_____ Phone #(___)_____

Insured's Name _____ Date of Birth ___/___/___ SS# _____

Insured's Address _____ City _____ State _____ Zip _____

<u>Please provide us with a copy of your insurance cards</u>

Health History

Primary Physician's Name_____ Phone #_____Last Exam Date_____

Other health care professionals you see_____

If you are presently being treated for a medical condition, please explain_____

Please list all prescription and non-prescription medications you take_____

_____

If you have ever had an allergic or adverse reaction to any medication, please list _____
_____

Have you ever taken medication for Osteoporosis?_____

Do you take aspirin regularly? _____ Do you use tobacco in any form? _____

Could you be pregnant at this time? _____ Due Date _____Are you taking birth controls pills? _____

Please place a check mark next to any condition that you have or have ever had:

_____ High blood pressure	_____ Seizures	_____ Kidney disease
_____ Bleeding tendency	_____ Fainting	_____ Liver disease
_____ Heart attack	_____ Dizziness	_____ Asthma
_____ Heart murmur	_____ Ringing in the ears	_____ Emphysema
_____ Heart surgery	_____ Cancer	_____ Tuberculosis
_____ Congenital heart defect	_____ Colitis	_____ Hepatitis
_____ Heart valve replacement	_____ Ulcers	_____ Venereal disease
_____ Rheumatic heart disease	_____ Stomach problems	_____ Thyroid disease
_____ Rheumatic fever	_____ Stroke	_____ Diabetes
_____ Joint replacement (hip, knee, etc.)	_____ AIDS	_____ Glaucoma
_____ Mitral valve prolapse	_____ HIV positive	_____ Persistent headaches
_____ Pacemaker		

Dental History

Date of last dental appt_____ Previous Dentist_____ City_____ Tele#_____

Have you ever been treated for periodontal disease? _____ Do you floss your teeth? _____

Do You Notice Chronic Bad Breath or Taste in your mouth? _____ Do You Experience Chronic Dry Mouth? _____

Do your gums bleed when you brush? _____ Do you grind your teeth? _____

Do you experience discomfort in your jaw joints (T.M.J.)? _____

Do you have difficulty chewing? _____ If you wear dentures, are they comfortable? _____

Do any areas of your teeth trap food? _____ Are any of your teeth sensitive to cold, heat or touch? _____

Would you like to change the appearance of your smile? _____

_____ _____ _____

Signature **Date** Reviewed By

Consent/Authorization/Acknowledgement

Clinical

I authorize the taking of necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize photos and radiographs to be mailed to referring providers and insurance companies.

I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

Financial/ Insurance

I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. Should my account become delinquent, I will assume all additional collection costs and legal fees.

A $50 Broken Appointment Fee will be charged to my account for all broken and/or last minute cancellations. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.

I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.

I understand I am responsible for the deductible, co-payment and excess over maximum the day of service.

HIPPA: Consent for Use and Disclosure of Health Information:

Notice of Privacy Practices: You have the right to read the practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices upon request.

I have had opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operations.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarification.

I also consent to disclosure of my healthcare information to my family:

Spouse ___ / Parent(s) ___ / Other(s) as listed ___/_____

_____/_____

Signature Circle One: Adult Patient / Parent / Guardian / Personal Representative Date