## PATIENT INFORMATION

**(Please Print)**

Name ______________________________ Birthdate _____-_____-______

Preferred Name___________________ Marital Status____________

Home Address_______________________________ Apt #_________

City___________________________ State_________ Zip_________

Please circle: Male Female

Who can we thank for referring you to our office?________________________________

### GENERAL INFORMATION (Parents)

- (Mr.) Name_________________________________ Phone:_________________
  Home Address________________________________ Apt#_________
  City _________________ State__________ Zip___________ Marital Status______
  Social Security Number________________________ DOB____________
  Occupation______________________ Employer ________________
  Email Address_______________________________________

- (Mrs., Miss., Ms.) Name____________________________ Phone:_______________
  Home Address________________________________ Apt #____________
  City_________________ State___________ Zip___________ Marital Status______
  Social Security Number___________________ DOB______________
  Occupation______________________ Employer________________
  Email Address _______________________________________

- Insurance Co.____________________________ Policy Holder:________________
  Insurance Address____________________________ Phone:________________
  Employee ID #__________________________ Group #___________________

- Secondary Insurance Co.________________________ Policy Holder:___________
  Insurance Address_________________________________ Phone:_______________
  Employee ID #__________________________ Group #___________________

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be hold 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, with my informed consent, any necessary dental services that I may need during diagnosis and treatment. Payment is due in full at time of service.

Signature:____________________________________________ Date:___________________

# PATIENT ADULT HISTORY

Patient Name:______________________________ Date of Birth:___________________________________

Although dental personnel primarily treat the area in and around your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes____ No____ If yes, please explain:______________________________
  ______________________________________________________________________________
- Are you taking any medications, pills or drugs? Yes____ No____ If yes, please explain:________________________
  ______________________________________________________________________________
- Have you ever had a serious head or neck injury? Yes____ No____ If yes, please explain:______________________
  ______________________________________________________________________________
- Have you ever been hospitalized or had a major operation? Yes____ No____ If yes, please explain:______________
  ______________________________________________________________________________
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biophosphonates?
  Yes____ No____ If yes, please explain:__________________________________________________________
- Do you use controlled substances? Yes____ N0_____ If yes, please explain:________________________________
  ______________________________________________________________________________
- Do you use tobacco? Yes____ No____ If yes, how much:_____________________________________________

**FOR WOMEN ONLY:**

Are you pregnant or trying to get pregnant? Yes____ No____ Are you nursing? Yes____ No____
Do you take oral contraceptives? Yes____ No_____

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

__ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex/Rubber __ Local Anesthetics __ Sulfa Drugs __ Other

**Do you have, or have you had, any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | __ Yes __ No | Diabetes | __ Yes __ No | Hives or Rash | __ Yes __ No |
| Anaphylaxis | __Yes __ No | Drug Addiction | __ Yes __ No | Kidney Problems | __ Yes __ No |
| Angina/Chest Pain | __ Yes __ No | Epilepsy or Seizures | __ Yes __ No | Osteoporosis | __ Yes __ No |
| Arthritis/Gout | __ Yes __ No | Excessive Bleeding | __ Yes __ No | Pain in Jaw Joints | __ Yes __ No |
| Artificial Joint | __ Yes __ No | Fainting Spells/Dizziness | __ Yes __ No | Parathyroid Disease | __ Yes __ No |
| Asthma/Lung Problems | __ Yes __ No | Glaucoma | __ Yes __ No | Shingles | __ Yes __ No |
| Blood Disease | __ Yes __ No | Heart Trouble/Disease | __ Yes __ No | Sinus Trouble | __ Yes __ No |
| Blood Transfusion | __ Yes __ No | Hepatitis | __ Yes __ No | Stomach/Intestinal Disease | __ Yes __ No |
| Bruise Easily | __ Yes __ No | Herpes | __ Yes __ No | Stroke | __ Yes __ No |
| Cancer | __ Yes __ No | High/Low Blood Pressure | __ Yes __ No | Thyroid Disease | __ Yes __ No |
| Chemo/Radiation | __ Yes __ No | High Cholesterol | __ Yes __ No | Tonsillitis | __ Yes __ No |
| Cold Sores/Fever Blisters | __ Yes __ No | | | Tuberculosis | __ Yes __ No |

Have you ever had any serious illness not listed? ___ Yes ___ No
Comments:______________________________________________________________________________
_______________________________________________________________________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
Signature:_____________________________________________ Date:___________________________________________

# PATIENT ADULT HISTORY

Patient Name:____________________ DOB: _____________ Today's Date_____________________

Previous Clip or release of Tongue, Lips or Cheeks?__________________________

**Has the patient experienced any of the following issues? Please check and elaborate as needed:**

Sleep Issues:
__ Sleeps in space positions
__ Kicks andflails around at night
__ Wakes easily or often
__ Wakes up tired and not refreshed
__ Grinds teeth while sleeping
__ Sleeps with mouth open
__ Snores while sleeping (how often) _________
__ Gasps for air or stops breathing (Sleep Apnea)
__ Has had a sleep study
__ Use a CPAP or oral appliance
__ History of Orthodontics/dental braces

Anything else we need to know?______________
________________________________________
Pediatrician/Family Practitioner:_______________
_________________Phone:________________
Speech Therapist:___________________________
_________________Phone:________________
Who referred you to us:_____________________
_________________Phone:________________

Other related issues:
Have now or had in the past:
__ Neck or shoulder pain or tension
__ TMJ pain, clicking, or popping
__ Headaches or migraines
__ Strong gag reflex
__ Mouth open/Mouth breathing during day
__ Tonsils or adenoids removed previously
__ Ear tubes previously
__ Reflux (medicated or not)
__ ADHD/ADD
__ Constipation
__ Speech issues

Comments:___________________________
____________________________________
____________________________________
____________________________________

_______________________DOCTOR USE ONLY_______________________

Exam: Palate_____ Gums_____ Lips: Type_____ Face_______ Occlusion_______ Throat form________
Tongue: Type___ Coated____ Cupping____ Lateralization_____ Anesthetic_____ Tropical ____ Local____
Treatment: Scissors___ Laser___ Settings:______________________Safety glasses worn___ Sutures____
Post Op
Instructions:_____________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

***Financial Policy***

Thank you for choosing us as your dental provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

***FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND CARE CREDIT.***

**Insurance**

We require all deductibles and co-pays be paid at the time of service. **The balance is your responsibility regardless of whether or not your insurance company pays for your claim**. We must have the correct insurance information in order for us to bill your insurance company. We are a 3rd party to the contract. **We file claims to your insurance as a courtesy to you. It's ultimately your responsibility to know and understand your dental insurance. IE: Coverages, Maximums and Frequencies; including deductibles**. If your insurance company has not paid your account within 60 days, the balance becomes your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

**Usual and Customary Rates**

Our practice is committed to providing the best possible care to our patients. Our fees are based on what is usual and customary for our area. You are responsible for payment regardless on insurance company's arbitrary determination of usual and customary rates.

**Unique Family Situations**

We will be happy to submit to either parent's insurance, however, **it is our office policy that the parent who brings the child in for their appointment is responsible for any co-pays and the balance on the account**.

**Missed Appointments**

We may apply a missed appointment fee for any missed appointments. We have set that time aside to serve our patients dental needs. We ask you respect that time by keeping scheduled appointments.

**Waver of Confidentiality**

You understand that if this account is submitted to an attorney or collection agency, if taken to court, or if your past due status is reported to a credit reporting agency, your treatment at our office may become a matter of public record.

***THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.***

***I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY:***

X______________________________________ **Date** ________________________

## HIPAA PATIENT ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES, CONSENT, AUTHORIZATION AND RECORDS RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ______________________

This undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices WHICH CAN BE FOUND IN a HARD BOUND BOOK IN OUR RECEPTION/WAITING ROOM for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI (protected health information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

______________________________ ______________________________
Please **PRINT** name of PATIENT (s) Please SIGN for Patient/Guardian of Patient

______________________________ ______________________________
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______________________________ ______________________________
Please **PRINT** name of PATIENT (s) Please SIGN for Patient/Guardian of Patient

______________________________ ______________________________
**PRINT** name Parent/Guardian Relationship to patient(s)

Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I AUTHORIZE CORRESPONDENCE FROM THIS OFFICE TO CONFIRM MY CHILD/CHILDREN(S) APPOINTMENTS, TREATMENT/HEALTH INFORMATION, AND BILLING INFORMATION, VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Mail
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

______________________________ ______________________________
**Signature of patient or parent/guardian** **Date**