Name _____Prefer to be called _____

Name of Medical Doctor _____ City/State_____

Emergency Contact _____Relationship_____Phone Number_____

Purpose of Dental Visit _____ Referred By _____

Are you having any pain or discomfort at this time?_____

When was your last dental visit?_____What was done at that time?_____

MEDICAL HISTORY

Have you ever been hospitalized or had surgery? _____

Do you require a pre-med?_____Reason?_____ Medication?_____

Are you currently taking blood thinners or have history of bleeding? _____

List all medications you are taking _____
IF EXTENSIVE, PLEASE LIST ON BACK OR INCLUDE A COPY OF LIST

Any **allergic reactions** (hives, rash, etc) to medications?_____

Do you have any history of the following conditions?

	Y	N
Heart Problems		
Chest Pain	☐	☐
Shortness of Breath	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Murmur	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Heart Surgery	☐	☐
Heart Attack/Failure	☐	☐
Blood Problems		
Easy Bruising	☐	☐
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Sickle Cell Disease	☐	☐
Diabetes	☐	☐
Autoimmune Disease		
Crohn's / Colitis	☐	☐
Lupus	☐	☐
Sjögren's syndrome	☐	☐
Multiple Sclerosis	☐	☐

	Y	N
Allergy Problems		
Seasonal Allergies	☐	☐
Sinus problems	☐	☐
Skin Rashes	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight Gain/Loss	☐	☐
Special Diet	☐	☐
Kidney Problems	☐	☐
Dialysis	☐	☐
Acid Reflux / Gerd	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Rheumatism	☐	☐
Joint Replacement	☐	☐
Osteoporosis	☐	☐
Pain in Jaw/TMJ	☐	☐
Cancer	☐	☐

	Y	N
Asthma	☐	☐
Seizures / Epilepsy	☐	☐
Migraine Headaches	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Fainting / Nervousness	☐	☐
Tuberculosis	☐	☐
Hepatitis / Liver Problems	☐	☐
Cold Sores	☐	☐
Shingles	☐	☐
HIV / AIDS	☐	☐
Anxiety or Depression	☐	☐
Psychiatric Treatment	☐	☐
Do you use alcohol?	☐	☐
How much? _____		
Do you smoke?	☐	☐
How much? _____		
Hx of Substance abuse?	☐	☐

If yes what kind? _____

When was it diagnosed? _____

Treatment received? _____

Women Are you Pregnant or planning on becoming Pregnant? _____ Are you nursing? _____

Any other condition / allergy that we should know about? _____

To the best of my knowledge all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctor and staff, if I have a change in my health status, including changes in my medications and/or allergies.

Signature (Patient of Parent if Minor) _____**Date**_____

Date: _____

Patient Information

Patient Name: _____ Birth Date: _____

Marital Status: _____ Gender: _____ Social Security # _____

Phone (Home): _____ Work: _____ Cell _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional series rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to patient _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to patient _____
Signature of guarantor of payment/responsible party

Office Policy

We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or doctor. We will document our record and depending on the severity of situation, you may be discharged from the practice.

Emergency Policy

Due to the complex nature of dentistry, patients will only be seen by the dentist during business hours with our assisting staff present. We offer an emergency line where the on-call dentist can return your call after hours to provide consultation, pharmacy prescriptions, appointment scheduling and palliative care. We will make every effort for you to be seen on the following day during office hours. If you are having a true medical emergency such as trouble breathing or significant swelling, it is recommended that you go to the closest Emergency Room or call 911.

We are committed to providing the best possible treatment and ask for your cooperation in following our policies.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Name:_____Date:_____

HIPAA Compliance Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your phone? YES NO

May we discuss your dental conditions with any member of your family? YES NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____