

Patient Information

Patient name: _____
Last, First MI

Birth Date: _____ Male Female Single Married Widowed Child Student F/T P/T

Social Security #: _____ Driver's License #: _____

Phone #: _____ Work #: _____ Cell #: _____

Address: _____
Street Apt. #

_____ City State Zip code

Email address to confirm appointments _____ @ _____ . Com

In case of emergency contact: _____
Name Phone# Relationship

Health Information

Date of last dental visit: _____ Reason for today's visit: _____

Have you ever had the following? Please check those that apply:

- | | | |
|---|---|---|
| Anemia <input type="checkbox"/> | Heart attack <input type="checkbox"/> | Respiratory problems <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Rheumatic fever <input type="checkbox"/> |
| Artificial valve/stent <input type="checkbox"/> | Hepatitis A, B, or C <input type="checkbox"/> | Scarlet fever <input type="checkbox"/> |
| Artificial joints <input type="checkbox"/> | High blood pressure <input type="checkbox"/> | Sinus problems <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | HIV/AIDS <input type="checkbox"/> | Substance abuse <input type="checkbox"/> |
| Aspirin a day <input type="checkbox"/> | Kidney disease <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Blood disease <input type="checkbox"/> | Liver disease <input type="checkbox"/> | Ulcers <input type="checkbox"/> |
| Blood thinners (coumidin/warfarin) <input type="checkbox"/> | Low blood pressure <input type="checkbox"/> | Thyroid disease <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Mitral valve prolapse <input type="checkbox"/> | Tobacco use <input type="checkbox"/> how much? _____ |
| Chemo/Radiation <input type="checkbox"/> | Nervous disorder <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Cong. Heart Failure <input type="checkbox"/> | Organ transplant <input type="checkbox"/> | Allergy Sulfa drugs <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | Allergy Penicillin <input type="checkbox"/> |
| Dizziness/fainting <input type="checkbox"/> | Phen-fen <input type="checkbox"/> | explain: _____ |
| Epilepsy <input type="checkbox"/> | Pregnant currently with due date _____ <input type="checkbox"/> | Allergy Latex <input type="checkbox"/> |
| Hearing impaired <input type="checkbox"/> | Premedicate before dental work <input type="checkbox"/> | explain: _____ |
| Taken Fosamax, Actonel, or Boniva <input type="checkbox"/> | | Allergy to other medications <input type="checkbox"/> |
| | | explain: _____ |

Currently taking any prescribed medications? Yes No

List: _____

Are you under the care of a physician now or within the past three years? Yes No

Explain: _____ Name of physician: _____ City: _____

Any health problems that need further clarification: Explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of patient or guardian X _____ Date: _____

Signature of doctor X _____ Date: _____

Employment Information

Insured Employer Name: _____ Occupation: _____
Employer Address: _____
Phone:() _____ Ext _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Y ____ N ____
Insured Social Security # _____ Insured Birth Date: _____
Insurance Plan Name: _____
ID#: _____ Group #: _____

Secondary

Name of Insured: _____ Is insured a patient? Y ____ N ____
Insured Social Security # _____ Insured Birth Date: _____
Insurance Plan Name: _____
ID#: _____ Group #: _____

Consent for Services

So you don't have to sign an insurance form at each dental visit, Dr. Paul M. Hoppe and Dr. Vanessa G. Cruz, will maintain this "signature on file" for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my provider, insurer or organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Signature: **X** _____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO ABOVE NAMED DENTIST: I hereby authorize payment directly to High Park Dental for services rendered.

Signature: **X** _____ Date: _____

(FOR OFFICE USE ONLY)

Rep Name: _____ Waiting Periods _____ FMX/pano _____ Prophy/4910 _____ Fl tx _____
Exam _____ Max _____ Available _____ Effective date _____ Renewal date _____
Ded. _____ Waived on P _____ Preventative _____ Basic _____ Major _____
NG _____ Post comp _____ BU: _____ Prior extractions: _____ Implant: _____
Replacement C&B/dentures _____ PPO Providers _____ E-claims _____

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION and DENTAL MATERIALS FACT SHEET

Name: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out dental treatment, payment activities, healthcare operations, and dental materials used. This is upon the demand of the State of California and HIPAA regulations.

Notice of Privacy Practices/Dental Materials: You have the right to read our Notice of Privacy Practices and Dental Materials Fact Sheet of May 2004, before you decide whether to sign this consent. Our Notice and Fact Sheet provide 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. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to High Park Dental Group. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we revised your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I had full opportunity to read and consider the contents of High Park Dental Group's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to High Park Dental Group to use and disclosure of my protected health information to carry out treatment, payment activities and health care opportunities.

In addition, I had full opportunity to read and consider the contents of The Dental Material Fact Sheet.

Signature: _____ Date: _____