David A. Scott, D.M.D. LLC.
GENERAL & COSMETIC DENTISTRY

The benefits of a healthy smile are immeasurable. Our goal is to allow you to obtain healthy teeth, and the attractive smile you deserve. Please complete this form so that we can provide the best care possible for you.

Name: _____ **Date of Birth**: _____
(Last) (First) (Middle)

Preferred Name: _____ **Parent/Guardian**: _____

Address: _____

Home Phone: _____ **Work**: _____Ext. _____ **Cell**: _____

Your Employer: _____ **Email Address:** _____

Social Security Number: _____ **Driver's License Number**: _____

Please select: Male ☐ Female ☐ *** Single ☐ Married ☐ Divorced ☐ Widowed ☐

If married, please list name of spouse: _____ **Work phone**: _____ **Cell**: _____

Incase of Emergency whom should we contact? _____ **Number**_____

Whom may we thank for referring you? _____

How would you prefer we contact you? Please check all that apply.

Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ E-mail ☐

INSURANCE INFORMATION: Insurance Card and a Photo ID will be needed upon arrival.

PRIMARY
Name of Insured: _____ **Relationship to patient**: _____

Insured's Date of Birth: _____ **Social Security Number**: _____

Name of Dental Insurance: _____**Contract Number**: _____

Group Number: _____ **Customer Service Phone Number**: _____

Employer: _____ **Employer Phone Number**: _____

Do you have additional insurance? Yes____ No____ If yes, please complete the following:

SECONDARY
Name of Insured: _____ **Relationship to patient**: _____

Insured's Date of Birth: _____ **Social Security Number**: _____

Name of Dental Insurance: _____**Contract Number**: _____

Group Number: _____ **Customer Service Phone Number**: _____

Employer: _____ **Employer Phone Number**: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, 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 dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? 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 had a serious head or neck injury? Yes☐ No☐ If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes☐ No☐ If yes, please explain: _____

Are you on a special diet? Yes☐ No☐ If yes, please explain: _____

Do you use tobacco? Yes☐ No☐ _____

Controlled substances? Yes☐ No☐ _____

(Women) Are you ☐ Pregnant/Trying to become pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other Allergies: _____

Have you ever had any of the following? Please check those that apply.

□ AIDS/HIV positive	□ Cold Sores	□ Head Injuries	□ Liver Disease	□ Sinus Problems
□ Alzheimer's Disease	□ Congenital Heart Disorder	□ Heart Attack/Failure	□ Low Blood Pressure	□Stomach/ IntestinalDisease
□ Anemia	□ Diabetes	□ Heart Murmur	□ Lung Disease	□ Stroke
□ Arthritis	□ Dizziness	□ Heart Pace Maker	□ Mitral Valve Prolapse	□ Swelling of Limbs
□ Artificial Joints	□ Drug Addiction	□ Hemophilia	□ Psychiatric Care	□ Thyroid Disease
□ Artificial Heart Valve	□ Epilepsy or Seizures	□ Hepatitis A,B or C	□ Radiation Treatments	□ Tonsillitis
□ Asthma	□ Excessive Bleeding	□ Herpes	□ Recent Weight Loss	□ Tuberculosis
□ Blood Disease	□ Excessive Thirst	□ High Blood Pressure	□ Renal Dialysis	□ Ulcers
□ Blood Transfusion	□ Fainting Spells	□ Hives or Rash	□ Rheumatic Fever	□ Venereal Disease
□ Breathing Problems	□ Frequent Cough	□ Hypoglycemia	□ Rheumatism	□ Jaundice
□ Cancer	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever	
□ Chemotherapy	□ Glaucoma	□ Kidney Disease	□ Shingles	
□ Chest Pains	□ Growths or Tumors	□ Leukemia	□ Sickle Cell Disease	

Have you ever had any serious illness not listed? Yes ☐ No ☐

If yes, please explain: _____

DENTAL HISTORY

Do your gums bleed while brushing or flossing? Yes☐ No☐

Are your teeth sensitive to hot or cold? Yes☐ No☐

Do you feel pain or soreness in any teeth? Yes☐ No☐

Do you have sores or lumps in your mouth? Yes ☐ No☐

Do you have frequent headaches? Yes ☐ No ☐

Do you clench or grind your teeth? Yes☐ No☐

Have you ever experienced any of the following problems in your jaw?

A) Clicking? Yes☐ No☐

B) Pain (joint, Ear, Side of face)? Yes☐ No☐

C) Difficulty in opening/closing? Yes☐ No☐

D) Difficulty in chewing? Yes☐ No☐

Date of your last dental visit _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

If you could easily and safely whiten your teeth, would you? Yes☐ No☐

If you could change anything about your smile, what would you like to do? _____

David A. Scott, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND FINANCIAL ARRANGEMENT

SECTION A: PATIENT GIVING CONSENT

X Patient Name / Parent or Guardian: _____

Relationship to patient: _____

Address same as patient? : Yes ☐ No ☐ _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I also give the staff employed by Dr. Scott permission to release my dental records at my request to another physician or dentist, if necessary.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice 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. A copy of our Notice accompanies this Consent. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dee A. Smith

Telephone: 205-758-5400 Fax: 205-758-5979

E-mail: info@davidscottdmd.com

Address: 1100 Englewood Village Drive Tuscaloosa, AL 35405

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 the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, X_____, have had full opportunity to read and consider the contents of this Consent form and your 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 heath care operations. I authorize and hereby request my insurance company to pay directly to Dr. David Scott for services rendered. I understand that my insurance company may pay less than the actual bill for treatment therefore; I am responsible for payment of all services rendered on my behalf or of my dependants. I realize that I am responsible for any late charges accrued on my account for balances not paid over 90 days and any collection and or attorney fees.

X Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

**************************************REVOCATION OF CONSENT***

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign: ☐Communications barriers prohibited obtaining the acknowledgement
☐An emergency situation prevented us from obtaining acknowledgement