PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services.
To assist us in serving you, please complete both sides of this form.

Name_____ Date of Birth _____/_____/_____ Sex: □ Male □ Female

Preferred Name_____ SS #_____-____-_____ Driver's License #_____

Address_____ Occupation _____

City_____ State____ Zip_____ Employer/School _____

□ Married □ Widowed □ Single □ Minor Employer/School Address _____

□ Separated □ Divorced □ Partnered for ___ years Employer/School Phone _____

Spouse's name_____ Spouse's Employer _____

Date of Birth _____/_____/_____ SS # _____-____-_____ Spouse's Phone (____) _____

CONTACT INFORMATION

Cell (____) _____ Home (____) _____ Work (____) _____ Ext____

Email _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name_____ Relationship _____ Phone (___) _____

WHOM MAY WE THANK FOR REFERRING YOU?

□ Doctor _____ □ Patient _____ □ Internet_____ □ Other _____

CANCELLATION POLICY

Your appointment is exclusively reserved for "You". If you are unable to keep your appointment please provide us with a **24-hour** notice to avoid a late cancellation or missed appointment fee. _____
Initial

DENTAL INSURANCE

Primary Dental Insurance _____

Address _____

Phone (____) _____

Group # _____ Subscriber ID# _____

Subscriber Name _____

SS# _____-____-_____ Date of Birth _____/_____/_____

Employer _____

Secondary Dental Company _____

Address _____

Phone (____) _____

Group # _____ Subscriber ID# _____

Subscriber Name _____

SS# _____-____-_____ Date of Birth _____/_____/_____

Employer _____

Insurance Assignment

I certify that I, and/or my dependants, have insurance coverage with _____ and assign directly to Dr. Melinda Pruitt all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information for treatment, payment and health care operations. I am responsible for the entire treatment amount after 60 days once insurance denials or pays less than estimated.

_____ _____ _____
Signature of Patient/Parent/Guardian | Please print name of Patient/Parent/Guardian | Date

COMPLETE OTHER SIDE →

HEALTH HISTORY

Name _____ Date of Birth ____/____/____ Social Security # _____-____-_____

Reason for today's visit _____

Former Dentist_____ City/State _____

Date of last dental visit _____ Date of last dental X-Rays _____

How often do you floss? _____ How often do you brush? _____

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

DENTAL HISTORY

	YES	NO		YES	NO		YES	NO
Bad Breath	☐	☐	Food collection between teeth	☐	☐	Orthodontic Treatment	☐	☐
Bleeding Gums	☐	☐	Foreign Objects	☐	☐	Pain around ear	☐	☐
Blisters on lips or mouth	☐	☐	Grinding Teeth	☐	☐	Periodontal Treatment	☐	☐
Burning sensation on tongue	☐	☐	Gums swollen or tender	☐	☐	Sensitivity to cold	☐	☐
Chew on one side of mouth	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to heat	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Clicking or popping jaw	☐	☐	Loose teeth or broken filling	☐	☐	Sensitivity when biting	☐	☐
Dry Mouth	☐	☐	Mouth Breathing	☐	☐	Sores/growths in mouth	☐	☐
Fingernail Biting	☐	☐	Mouth pain, brushing	☐	☐			

MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Respiratory Disease	☐	☐
Anemia	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
Back Problems	☐	☐	Hepatitis Type	☐	☐	Special Diet	☐	☐
Bleeding abnormally, with			Herpes	☐	☐	Stroke	☐	☐
extraction or surgery	☐	☐	High Blood Pressure	☐	☐	Swollen Feet or Ankles	☐	☐
Blood Disease	☐	☐	Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Cancer	☐	☐	Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Chemical dependency	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Low Blood Pressure	☐	☐	Tumor/Growth on		
Congenital Heart Lesions	☐	☐	Mitral Valve Prolapse	☐	☐	head or neck	☐	☐
Cortisone Treatments	☐	☐	Nervous Problems	☐	☐	Ulcer	☐	☐
Cough, Persistent/Bloody	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐	Weight Loss	☐	☐
Emphysema	☐	☐	Radiation Treatment	☐	☐			

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex or rubber dam
☐ Local Anesthetic ("Novocaine")
☐ Penicillin
☐ Other _____

_____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received a copy of

Dr. Melinda Pruitt's Notice of Privacy Policies.

_____
Name (print)

_____ _____
Signature Date

OFFICE USE ONLY

On _____, an *Acknowledgment of Receipt of Notice of Privacy Policies* form was delivered. The form was not signed due to:

- ❑ Communication barriers which prevent acknowledgement
- ❑ An emergency which prevent acknowledgement
- ❑ A refusal to sign
- ❑ Other _____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.

The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.

Melinda W. Pruitt, D.D.S • Michael Horwitz, D.D.S
1245 16th Street, Suite 209 • Santa Monica, CA 90404 • Tel (310)453-1223 • Fax (310) 453-8757

COMPLETE OTHER SIDE →

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact: The Office Administrator at (310) 453-1223.

Patient's Consent

Name: _____ Telephone: (_____)_____

Address: _____ E-mail: _____

City: _____ Social Security #: _____-____-_____

State: _____ Zip: _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature **to revoke authorization**: _____ Date: _____

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____