Dr. Robert T. Hoyle, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

I, ____________________________, have received a copy of this office’s Notice of Privacy Practices.

Please Print Name

______________________________

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

☐ Other (Please Specify)

______________________________

______________________________

______________________________
### GETTING TO KNOW YOU AS OUR PATIENT

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>HOME PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>City, State, Zip</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drivers License and State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Primary Insurance Company

Group

Subscriber

Secondary Insurance Company

Group

Subscriber

<table>
<thead>
<tr>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>City, State, Zip</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Drivers License and State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Person's Employer</th>
<th>Occupation</th>
<th>Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Name</th>
<th>Social Security Number</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Employer</th>
<th>Spouse's Occupation</th>
<th>Spouse's Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Business Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### How did you hear about our Office?

(check only one)

- Referred by a friend
- Yellow Pages
- Relative
- Insurance Plan
- Welcome Wagon
- Other
- TV/Radio Ad
- Newspaper Ad
- Direct Mailing
- Sign by Building

If you were referred, whom may we thank for referring you?

### CONSENT

I will answer all health questions to the best of my knowledge ____________________________

Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature ____________________________

Date ____________________________

Relationship to Patient ____________________________

### TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed ____________________________

Date ____________________________

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.
**PATIENTS DENTAL HEALTH**

**Why have you come in to see us today? (e.g.: pain, checkup, etc.)**

**Previous Dentist** __________________ Last Visit ________ Date of last cleaning ________

**Reasons for changing dentists:**

**What problems have you had with past dental treatment?**

**Are you nervous about seeing a dentist?**

- Yes
- No
- If yes, please tell us why:

**How often do you brush?**

- Yes
- No
- How often?

(please circle each)

- Y N I clench or grind my teeth during the day or while sleeping.
- Y N My gums bleed while brushing or flossing.
- Y N I like my smile.
- Y N I prefer tooth-colored fillings.
- Y N I avoid brushing part of my mouth due to pain.

**What are your dental priorities?**

(please circle each)

- Y N Infection
- Y N Attrition
- Y N Esthetics
- Y N I want my teeth straight.
- Y N I want my teeth white.

**PATIENTS MEDICAL HISTORY**

I consider my health to be

- Excellent
- Good
- Fair
- Poor

Do you or have you had any of the following? Please circle Y for yes or N for no.

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Raynaud's Disease
12. Y N Sinus Trouble
13. Y N Epilepsy
14. Y N Ulcers
15. Y N Implants/Artificial Joints:  Hip, Knee, Other
16. Y N I smoke or use tobacco. If yes, how much per day? How many years?
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I have consumed alcohol within the last 24 hours.
19. Y N I have ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year Type of operation: Year Type of operation:
21. Y N Do you have any other medical problem or medical history NOT listed on this form?

Are you allergic to any of the following? Please circle Y for yes or N for no.

- Y N Aspirin
- Y N Ibuprofen
- Y N Sulfa Drugs/Chloramphenicol
- Y N Penicillin
- Y N Codeine
- Y N Latex, Metals, Plastics
- Y N Local Anesthetics (Novocaine)
- Y N Other Medications - Which ones?

In the event of an emergency please contact:

Name __________________________ Relationship __________________________ Phone __________________________

Name __________________________ Relationship __________________________ Phone __________________________

Initial medical/dental health reviewed by:

Doctor's Signature __________________________ Date ________ X Patient's Signature __________________________ Date ________

Periodic medical/dental health reviewed by:

Doctor's Signature __________________________ Date ________ X If patient is a minor: Parent/Guardian's Signature __________________________ Date ________

**GETTING TO KNOW YOU AS OUR PATIENT**