PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

You have permission to discuss my treatment, billing, and health care options with The following individuals: ______________________________

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Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ____________________

PATIENT INFORMATION (CONFIDENTIAL)

NAME ______________________________ DATE ____________
FIRST MI LAST

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

E-MAIL ____________ CELL PHONE ____________ HOME PHONE ____________

SS#/SIN ____________ BIRTHDATE ____________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL ____________ CITY ________ STATE ______

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER ____________ WORK PHONE ____________

EMPLOYER ADDRESS ____________ CITY ____________ STATE ______ ZIP ________

SPOUSE OR PARENT'S/GUARDIAN'S NAME ______________________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________ PHONE ____________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________ RELATIONSHIP TO PATIENT ____________

ADDRESS ______________________________ HOME PHONE ____________

DRIVER'S LICENSE # ____________ BIRTHDATE ____________ SS#/SIN ____________

EMPLOYER ______________________________ WORK PHONE ____________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS#/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ______________________________ WORK PHONE ____________

EMPLOYER ADDRESS ____________ CITY ____________ STATE ______ ZIP ________

INSURANCE CO. ____________ TEL. # ____________ GRP # ____________ POLICY / I.D. # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE ______ ZIP ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS#/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ______________________________ WORK PHONE ____________

EMPLOYER ADDRESS ____________ CITY ____________ STATE ______ ZIP ________

INSURANCE CO. ____________ TEL. # ____________ GRP # ____________ POLICY / I.D. # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE ______ ZIP ________

PATIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN ______________________ OFFICE PHONE ______________________ DATE OF LAST EXAM ______________________

	YES	NO
1. Are you under medical treatment now? For: ______________________	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ______________________	❑	❑
4. Are you on medication for Osteoporosis?	❑	❑
5. Are you on blood thinners?	❑	❑
6. Do you use tobacco? ❑ Pipe ❑ Cigarette ❑ Chew	❑	❑
7. Do you use alcohol?	❑	❑
8. Do you use controlled substances?	❑	❑

9. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	❑	❑	Codeine	❑	❑	Aspirin	❑	❑
Penicillin	❑	❑	Sedatives	❑	❑	Latex/Rubber	❑	❑
Other Antibiotics	❑	❑	Sulfa Drugs	❑	❑	Metal/Jewelry	❑	❑

Other ______________________

10. WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking brith control pills?	❑	❑

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

	YES	NO		YES	NO		YES	NO
Low/High Blood Pressure	❑	❑	Heart Murmur or Defect	❑	❑	Easily Winded	❑	❑
Heart Attack or Angina	❑	❑	Pacemaker	❑	❑	Stroke	❑	❑
Rheumatic Fever	❑	❑	Sinus Trouble	❑	❑	Hay Fever / Allergies	❑	❑
Fainting / Seizures	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Asthma	❑	❑	Emphysema	❑	❑	Mental Health Care	❑	❑
Chemotherapy	❑	❑	Cancer / Leukemia	❑	❑	Cold Sore / Fever Blisters	❑	❑
Epilepsy/Convulsions	❑	❑	Arthritis	❑	❑	Respiratory Problems	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Eating Disorders	❑	❑
Metal Pins / Screws	❑	❑	Hepatitis / Jaundice	❑	❑	Other ______________	❑	❑
AIDS or HIV Infection	❑	❑	Chemical Dependency	❑	❑	______________	❑	❑
Heart Disease	❑	❑	Chest Pains	❑	❑	______________	❑	❑
						______________	❑	❑

PATIENT DENTAL HISTORY

1. How LONG SINCE you have seen a dentist? ______________________

2. Are you having problems now? ______________________ WHAT?

	YES	NO
3. Do your gums bleed while brushing or flossing?	❑	❑
4. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
5. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
6. Do you feel pain to any of your teeth?	❑	❑
7. Do you have any sores or lumps in or near your mouth?	❑	❑
8. Have you had any head, neck or jaw injuries?	❑	❑
9. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) Difficulty in chewing?	❑	❑
10. Do you have frequent headaches?	❑	❑
11. Do you clench or grind your teeth?	❑	❑
12. Have you had any orthodontic treatment?	❑	❑
13. Have you ever had prolonged bleeding following extractions?	❑	❑
14. Have you ever had instructions on the care of your gums?	❑	❑
15. Has your dental care been IRREGULAR in the last 5 yrs?	❑	❑
16. Do you expect to wear DENTURES someday?	❑	❑
17. Have you had BAD dental experiences in the past?	❑	❑
18. Are you APPREHENSIVE about dental treatment?	❑	❑
19. Have you ever had NITROUS OXIDE (laughing gas) before?	❑	❑
20. Would you like to have the gas for dental treatment?	❑	❑
21. Are you dissatisfied with any PAST dental treatment?	❑	❑
22. Have you ever had any PERIODONTAL (GUM) treatments?	❑	❑
23. Are you troubled by BAD BREATH?	❑	❑
24. Does food usually WEDGE between certain teeth? Where? ______________________	❑	❑
25. Are you UNHAPPY with the APPEARANCE of your teeth?	❑	❑
26. Have you had the NERVES of any teeth REMOVED?	❑	❑
27. Have any teeth DARKENED from nerve removal/Endodontics?	❑	❑
28. Do you REGULARLY use DENTAL FLOSS?	❑	❑
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑

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IF PATIENT IS A CHILD

	YES	NO
1. Has your child had any unhappy dental experiences?	❑	❑
2. Has you child had any injuries to his/her mouth/teeth/head?	❑	❑
3. Does your child have any mouth habits? Thumb sucking, Nail Biting, Mouth Breathing, Nursing Bottle Habits, etc.?	❑	❑
4. Does your child have any unusual speech habits?	❑	❑
5. Has orthodontic treatment been recommended?	❑	❑
6. Does your child brush daily?	❑	❑
7. Do you assist your child with tooth brushing?	❑	❑
8. Is Dental Floss used?	❑	❑
9. Is Fluoride taken in any form?	❑	❑

I certify that I have read & understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE ______________________ (PATIENT, PARENT, GUARDIAN) DATE ______________________