PERFECT SMILES
FAMILY DENTISTRY

Confidential Information

## 1 Patient Information

Name: .....

I prefer to be called: ..... ☐ Male ☐ Female

Date of Birth: ..... SSN: .....

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

Home Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐ Profession: _____

Employer/School: .....

Employer/School Address: .....

.....

Spouse/Guardian's Name: .....

Whom may we thank for referring you? .....

☐ Yellow Pages ☐ Magazines ☐ Mailers ☐ Friend
☐ Family ☐ Yahoo! ☐ Google ☐ Other

## 2 Responsible Party

Person Responsible for this Account: .....

Relationship to Patient: .....

Date of Birth: ..... SSN: .....

Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐

Driver's License: ..... Employer: .....

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Visa ☐ MasterCard
☐ Health Loan Service ☐ I wish to discuss the office's payment policy

Emergency Contact Name: .....

Home: ..... ☐ Work: ..... ☐

## 3 Insurance Information

**Primary Insurance**

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

**Secondary Insurance**

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

**Signature on file:**
**Perfect Smiles Family Dentistry** is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

X _____ Date: _____

**Patient or authorized person's signature**

Confidential Information

# 4 Patient Medical History

| | Yes | No |
|---|---|---|
| 1. Do you have a personal physician? | ☐ | ☐ |
| a) Physician's Name: _____ | | |
| b) Physician's Office Phone: _____ | | |
| c) Date of Last Exam _____ | | |
| 2. Are you under medical treatment now? | ☐ | ☐ |
| 3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 4. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | ☐ | ☐ |
| 5. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 6. Do you use tobacco? | ☐ | ☐ |
| 7. Do you use controlled substances? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 9. Do you use contact lenses? | ☐ | ☐ |
| 10. Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |
| 11. Do you have a persistant cough or throat clearing not associated with a known illness? (lasting more than 3 weeks) | ☐ | ☐ |
| 12. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

8. Do you have or have you ever had any of the followings?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS or HIV Infection | ☐ | ☐ | Glaucoma | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Anemia | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Angina | ☐ | ☐ | Heart Attack | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Disease | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Cancer | ☐ | ☐ | Heart Trouble | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Chest Pains | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement / Implant | ☐ | ☐ | Stroke | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Kidney Diseases | ☐ | ☐ | Swollen Ankles | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Leukemia | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Liver Disease | ☐ | ☐ | Thyroid Problem | ☐ | ☐ |
| Frequently Tired | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Other _____ | ☐ | ☐ |

# 5 Patient Dental History

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do any of your teeth hurt? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck, or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you seen an orthodontist for treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? | ☐ | ☐ |
| If yes, how old are they? _____ | ☐ | ☐ |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

I certify that I have read and understand the above. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be harmful to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to **Perfect Smiles Family Dentistry** or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ Date: _____

**Signature of patient (or parent/guardian if minor)**

Doctor's Comments: _____

_____ Date: _____

_____ Date: _____

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

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**Scheduling/Cancellation Policy:**

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us out by keeping your scheduled appointments, and by notifying us in advance if you are unable to do. With advance notice, we are often able to accommodate other patients that are willing to get an appointment.

Please read and sign our policy statement below:

**IF YOU NEED TO CANCEL AN APPOINTMENT, PLEASE DO SO AT LEAST 24 HOURS IN ADVANCE.**

**ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 24 HOURS ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE OF $25.00 PER HOUR SCHEDULED.**

We thank you for your assistance in complying with this policy and appreciate your cooperation.

I, _____ have read and understand this policy.
Patient Name

_____

Patient Signature