

PATIENT INFORMATION & HEALTH UPDATE

To keep your record accurate, please complete all sections, sign, and date below.

You may be required to update this form regularly.

Date: _____ Birth Date: ____/____/____

Patient Name: _____
Last First MI

Phone (Home): _____ (Cell) _____ (Work) _____

Email Address _____

Address: _____

Insurance: _____
Company Employer

Please list all current medications (include vitamins and store bought medications)

Are you required to premedicate with antibiotics prior to dental treatment, due to a heart murmur or joint replacement surgery? If so, what medication does your doctor prescribe?

Are you currently pregnant or trying to get pregnant? YES NO Due Date: _____

Tobacco Use- Cigarettes/ Vaping/ E-Cig/ Other: _____ How often: _____ Use: Current/ Past

Check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Acid Reflux/ Gerd
<input type="checkbox"/> AIDS
<div style="border: 1px solid blue; padding: 2px; display: inline-block; margin-top: 5px;"> Allergic to
 <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Codeine
 <input type="checkbox"/> Latex <input type="checkbox"/> NSAIDs
 <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa
 <input type="checkbox"/> Other _____ </div> | <input type="checkbox"/> Cold Sores
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Eating Disorder
(type) _____
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis (type) _____ | <input type="checkbox"/> HIV
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HPV
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> Pace Maker
<input type="checkbox"/> Radiation
(where) _____
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Surgery
(type) _____
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
(when) _____
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Vertigo
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other
_____ |
|---|--|---|--|

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment, without fail.

Signature: _____ Date: _____



OFFICE POLICIES

MISSION STATEMENT

Our goal and policy is to treat our patients as we would treat our families. We will always offer high-quality, friendly service in a gentle, caring atmosphere. Our patients are the heart of our practice and the reason we are here. At all times our patients will be treated with respect, dignity and compassion. Being of service to our patients is the definition of our purpose and the mission of our practice.

INSURANCE

OUR OFFICE FILES INSURANCE BENEFITS AS A COURTESY ONLY. Please be aware that insurance is an agreement between the patient and the insurance company. Therefore, the patient/ primary policy holder is responsible for any unpaid balances. Questions regarding unpaid claims should be discussed with the patient's insurance carrier.

PAYMENT OPTIONS

PAYMENT IS DUE WHEN SERVICES ARE RENDERED, unless prior arrangements were made. Our office accepts all major credit cards (Visa, Master Card, American Express and Discover). We also offer lines of credit through Care Credit and accept cash or personal check.

Some patients do not enjoy coming to the dentist. Therefore, we strive to give our patients a professional and relaxed atmosphere to make them feel more at ease. In order to maintain this level of comfort, we request all children have adult supervision and not be left unattended.

Patient Name _____

Patient Signature _____ Date _____



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Please read over attached **Notice of Privacy Practice** before signing below. You may refuse to sign this acknowledgement.

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

Patient Name _____

Patient Signature _____ Date _____

Once this page has been signed, it will be placed in your records as written acknowledgement of receipt of the Notice of Privacy Practices.

Authorization for Release of Information

Our office is authorized to release protected health information about patient named above to the entities below. If none, please write NONE and sign & date.

Name	Relationship	Information to be disclosed	
_____	_____	Dental	Financial
_____	_____	Dental	Financial
_____	_____	Dental	Financial

Patient Signature _____ Date _____



NOTICE OF PRIVACY PRACTICES

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you with your authorization for several other reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the reception area. You can also request a copy of our notice at any time. For more information about our privacy practice, contact the office below.

YOUR RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

The following is a statement of your rights to your health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact our office at 704-871-1413.