WELCOME

PLEASE ANSWER ALL THE FOLLOWING INFORMATION CLEARLY

Last Name _____ Name _____

Date of Birth _____ Age _____ Gender _____

Nationality _____ Social Security _____

Address _____

City _____ State _____ Zip _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Occupation _____ Email: _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

What is the best way to reach you? ____ Home ____ Cell ____ Work

Emergency Contact
Name: _____

Relationship to patient: _____ Phone number (_____) _____

How did you hear about us? _____

Person responsible of payments if not the patient
Name: _____

Address : _____
City State Zip Code

Name of Employer: _____

Work Phone Number: _____

Phone Number: _____ Social Security Number: _____

DOB: _____

Relationship to patient: _____

Patient signature or Legal Guardian _____ Date _____

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

PLEASE CIRCLE THE CORRECT ANSWER

Yes No Are you good in health in general?
Yes No Have you been hospitalized or had any serious disease in the past three years?
If yes, why?
Yes No Are you under any medical treatment? What for?_____
Date of your last medical exam: _____ Date of your last dental appointment: _____
Yes No Have you have any issues with any dental treatment in the past?
Yes No Do you have any pain now? Explain: _____

TAKING:

Yes No Remedies, Medicine with or without prescription (including aspirin)

Please list all: _____

DO YOU CONSUME

Yes No Recreational drugs?
Yes No Tobacco any type? How many a day? _____ Yes No Alcohol (Alcoholic drinks)?

ONLY FOR WOMEN:

Yes No Are you or could you be pregnant? How many weeks? _____ Yes No Are you breast feeding?
Yes No Are you taking birth control pills?

MARK <u>ONLY IF YOU HAVE OR HAVE HAD IN THE PAST:</u>

- ☐ Heart disease
- ☐ Heart Attack
- ☐ Heart Murmurs
- ☐ Diabetes
- ☐ Rheumatic fiber
- ☐ High Blood Pressure
- ☐ Skin diseases
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Venereal disease
- ☐ Hepatitis or other liver disease
- ☐ Stomach problems, ulcers
- ☐ Psychiatric treatment
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ AIDS o HIV positive
- ☐ Tumors, Cancer
- ☐ Alcohol abuse
- ☐ Arthritis, rheumatism
- ☐ Eye illness
- ☐ Blood disease
- ☐ Anemia
- ☐ Asthma
- ☐ Other pulmonary problems
- ☐ Herpes
- ☐ Thyroid or glands problems
- ☐ Kidney problems
- ☐ Hospitalizations
- ☐ Blood transfusions
- ☐ Surgeries
- ☐ Pacemakers
- ☐ Seizures

Specify _____

Yes No **ALERGIES** (food, medicine, latex, others) Please specify

_____

Yes No Do you have or had any other medical condition that we need to know about?

If yes, please explain: _____

I acknowledge that I have answered completely and correctly to all the above questions. I will notify my dentist if there are any changes concerning my health or the medicine I take.

Patient Signature or Legal Representative _____ Date _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

(You may refuse to sign this acknowledgement & authorization. If refusing, we may not be allowed to process your insurance claims)

Date: ________________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

___________________________________	___________________________________
Please print your name	Please sign your name
___________________________________	___________________________________
Legal Representative	Description of the Authority

Your comments regarding Acknowledgements or Consents: ____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ___________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: ________________________________ Relationship: __________________________________

Name: ________________________________ Relationship: __________________________________

Name: ________________________________ Relationship: __________________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENTS AND BILLING INFORMATION VIA:

- ☐ Cellphone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to My Cell Phone
- ☐ Email Confirmation
- ☐ All of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- ☐ Cellphone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to My Cell Phone
- ☐ Email Confirmation
- ☐ All of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ All of the above
- ☐ None of the above (Opt out)

Signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rude, provide you this information with your knowledge and consent.

Office use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because:
- Other (please describe)

____
Privacy Officer Signature

APPOINTMENT CANCELLATION POLICY

We understand that situations arise in which you must cancel your appointment. However, when you do not call to cancel your appointment, you may be preventing another patient from receiving treatment. It is therefore requested that you provide more than 24-hour notice when cancelling your appointment; allowing another patient the appointment time.

Appointments which are cancelled with less than 24 hours notification, will be subject to a $50.00 cancellation fee.

NO SHOW POLICY

Patients who do not show up for their appointments without calling to cancel, will be considered as NO SHOW and subject to a $50.00 NO SHOW fee. Patients who NO SHOW two or more times in a 12 months period, may be dismissed from the practice and denied any future appointments.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance does not cover this charge.

_____ _____

Patient's Name DOB

_____

Legal Guardian's Name

_____ _____

Patient's Signature (or Legal Guardian) Date