

Patient Information



PERSONAL INFORMATION

Parent/Guardian: _____ Sex: M F Unknown DOB: _____
 Address: _____ City: _____ ST: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email Address: _____ May we text you? Yes No

Patient Name: _____ Sex: M F U DOB: _____
 Patient Name: _____ Sex: M F U DOB: _____
 Patient Name: _____ Sex: M F U DOB: _____
 Patient Name: _____ Sex: M F U DOB: _____
 Patient Name: _____ Sex: M F U DOB: _____



CONFIDENTIAL & EMERGENCY CONTACT INFORMATION

Please list the family members (or other persons), if any, with whom we may discuss dental treatment and/or diagnosis and release records.

Name: _____ Phone: _____
 Emergency Contact Discuss Treatment Consent for Treatment Release Records

Name: _____ Phone: _____
 Emergency Contact Discuss Treatment Consent for Treatment Release Records

Name: _____ Phone: _____
 Emergency Contact Discuss Treatment Consent for Treatment Release Records

X _____
SIGNATURE PRINTED NAME DATE

INITIALS I authorize the office employees to send school excuses to the school employees and to inform the school if my child had a dental appointment and the date release to go back to school.



HOW DID YOU HEAR ABOUT US?

- Email Office Outreach (phone) Mailer Newspaper
 Radio Community Event School Event Grocery Store
 Social Media Friend/Family Google Search Walk-in
 Other: _____



PRIVACY PRACTICES

I, _____, have received a copy of the Notice of Privacy Practices. I understand that the purpose of this form is to document that this office has made an effort in helping me be aware of the required privacy practices under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

X _____
SIGNATURE PRINTED NAME DATE

INITIALS I have been made aware that the Providers are contracted Dentists.

Medical History



PERSONAL INFORMATION

Patient Name: _____ DOB: _____

Preferred Language: English Spanish Other: _____

Ethnicity: _____ Race: _____



DENTAL INFORMATION

Are you having any pain or sensitivity at this time (or recently)? No Yes

If yes, please explain: _____

Do you have any dental problems right now that you are aware of? No Yes

If yes, please explain: _____

Are you interested in a free orthodontic consultation? No Yes



MEDICAL INFORMATION

Are you, or do you think you may be pregnant? No Yes

Are you being treated by a physician now? No Yes Reason: _____

Taking any medications? No Yes Identify: _____

Allergic to any medications? No Yes Identify: _____

Allergic to metals? No Yes Identify: _____

Any recent serious illnesses? No Yes Identify: _____

Have you ever had any major surgery? No Yes Identify: _____

Please CHECK any of the following which you have had (or presently have).

Heart Trouble

Diabetes

Eye Disorder

Tuberculosis

Hepatitis

Arthritis

Thyroid Condition

Heart Murmur

Latex Sensitivity

Bruise Easily

Head Lice

Flu

Stroke

Rheumatic Fever

Tumors/Growth Prolonged

Asthma

AIDS (HIV+)

Allergic to Anesthetic

Stomach/Intestinal Problems

Artificial Heart Valve

Cold Sores/Fever Blisters

Psychiatric/Psychological Care

Pink Eye

Other (Contagious): _____

High Blood Pressure

Kidney/Liver Disorder

Bleeding

Epilepsy

Venereal Disease

Smoking or Chewing

Birth Control Pills

Ulcers

Fainting/Dizzy Spells

Whooping Cough

Bronchitis

Are there any other medical problems that we should be aware of? No Yes

If yes, please explain: _____

The information above is accurate to the best of my knowledge.

X _____

SIGNATURE

PRINTED NAME

DATE



PRESCRIPTION FOR DENTAL RADIOGRAPHS

Patient Name _____ DOB _____

Does the patient have any known allergies or medical conditions? No Yes

If yes, please explain:

I authorize the Provider to take the necessary x-rays as the Provider recommends.

Patient/Guardian Name (Print) _____ Date _____

Patient/Guardian Signature _____



PRESCRIPCIÓN PARA RADIOGRAFÍAS DENTALES

Nombre del Paciente _____ FDN _____

¿El paciente tiene alguna alergia o condiciones médicas? No Si

Por favor, explique:

Autorizo al proveedor a tomar las radiografías necesarias como el proveedor recomienda.

Nombre Tutor/Paciente _____ Fecha _____

Firma del Tutor/Paciente _____

For Provider: After careful consideration of the dental or other health needs of the patient, I am prescribing the following dental radiographs as I find them necessary for diagnosis, treatment, prevention of disease and monitoring of growth and development.

Periapical Radiographs How many? _____
 Bitewings Radiographs How many? _____

FMX Panoramic Film Cephalometric X-ray

Other: _____

Provider Name: _____

Signature: _____



INSURANCE FILING AUTHORIZATION

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or the dental practice contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with all claims associated with the recipients on my insurance plan.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above dental entity.

Name of Guardian _____

Guardian's Signature _____ Date _____

Patient Name: _____	Sex: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> U	DOB: _____
Patient Name: _____	Sex: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> U	DOB: _____
Patient Name: _____	Sex: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> U	DOB: _____
Patient Name: _____	Sex: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> U	DOB: _____
Patient Name: _____	Sex: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> U	DOB: _____



AUTORIZACIÓN DE PAGOS DE BENEFICIOS DE LA ASEGURANZA

Se me ha informado del plan de tratamiento y los costos asociados. Estoy de acuerdo en ser responsable de todos los cargos por servicios dentales y materiales no cubiertos por mi plan de beneficios dentales, a menos que esté prohibido por ley, o el dentista que hará el tratamiento dental o la clinica dental tiene contrato con mi plan que prohiban toda o una parte de dichos cargos. En la medida permitida por la ley, doy mi consentimiento para el uso de la divulgación de mi información protegida de salud para llevar a cabo actividades de pago en relación con todas las reclamaciones y cargos de mi seguridad.

Doy permiso y ordeno el pago de los beneficios dentales de otro modo pagados a mi, directamente a la entidad dental anterior.

Nombre del Guardián _____

Firma _____ Fecha _____

Nombre del Paciente: _____	Género: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> D	FDN: _____
Nombre del Paciente: _____	Género: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> D	FDN: _____
Nombre del Paciente: _____	Género: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> D	FDN: _____
Nombre del Paciente: _____	Género: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> D	FDN: _____
Nombre del Paciente: _____	Género: <input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> D	FDN: _____



CONFIDENTIAL COMMUNICATION REQUEST

Name of Patient _____ DOB _____
 Name of Patient _____ DOB _____
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As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask you why you are making your request, and will try to accommodate all reasonable requests.

_____ (print name) hereby requests the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply.

PHONE

I want you to contact me by telephone at this primary number: _____

- DO DO NOT Leave messages on my answering machine or voicemail.
 DO DO NOT Leave messages with any other person.

MAIL

I want you to contact me at the following primary address: _____
 City _____ ST _____ Zip _____

EMAIL

I want you to contact me at this email address: _____

FAX

I want you to contact me at this fax number: _____

OTHER REQUESTS FOR CONFIDENTIAL COMMUNICATIONS

(SPECIFY): _____

Patient/Guardian Signature _____ Date _____

Employee Printed Name _____