Welcome, thank you for selecting our dental team!

To help us better serve you, please fill out the following 4 forms for us.

Price Family Dentistry

Patient Information:

Patient: _____ Today's Date: _____

SSN: _____Driver's License # _____

Gender: _____

Date of Birth: _____ Age: _____

Marital Status: ___Minor ___Single ___Married/Partnership (Spouse's Name:_____)

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Work#: _____Email: _____

Which number is best for communication with you? _____

Occupation: _____

In case of emergency who should be notified?

Name: _____ Phone: _____

Relationship: _____

Whom may we thank for referring you? _____

Dental History and Information:

What has brought you to our office today? _____

Previous Dentist? _____

Last Dental Visit? _____Last Full Mouth X-rays? _____

How many times a day do you brush? _____ Floss _____

Do your gums bleed when brushing? _____Are you in any type of dental pain? _____

Are any of your teeth sensitive? _____Do you grind/clench your teeth? _____

Do you use tobacco products? _____ If so, describe: _____

Have you ever had gum disease therapy or deep cleaning? _____

If so, describe: _____

Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? _____

Would you like your teeth to be whiter? _____

Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____ If so, please ask our office assistant for a brochure on dental financing. She can help you and answer any questions that you may have.

MEDICAL HISTORY AND INFORMATION:

Patient Name: _____ Date: _____

Physician's Name: _____ Physician's Phone #_____

Do you have any Drug Allergies or have you ever had an adverse reaction to any medication? ____Yes ____No
Please List: _____
Has a physician directed you to take antibiotics prior to having dental treatment? _____Yes _____No
Have you had a joint replacement or heart valve replacement within the last year? _____Yes _____No
If yes, please take your Pre-Med antibiotic as prescribed by your physician prior to your appointment.

***Please check if you have any of the following:*

_____ Abnormal Bleeding	_____Fever Blisters	_____PRE-MED
_____Anemia	_____Frequent Headaches	_____Pace Maker
_____Angina Pectoris	_____Glaucoma	_____Pneumocystis
_____Arthritis	_____HIV + / AIDS	_____Psychiatric Problems
_____Artificial Joints	_____Hay Fever	_____Radiation Therapy
_____Artificial Valve	_____Heart Attack	_____Rheumatic Fever
_____Asthma	_____Heart Disease	_____Seizures
_____Blood Transfusion	_____Heart Murmur	_____Shingles
_____Cancer – Chemotherapy	_____Heart Surgery	_____Sickle Cell Disease
_____Congenital Heart Defect	_____Hemophilia	_____Sinus Problems
_____Cosmetic Surgery	_____Hepatitis Type ____	_____Stroke
_____Diabetes	_____High Blood Pressure	_____Thyroid Problems
_____Difficulty Breathing	_____Kidney Problems	_____Tuberculosis
_____Drug Abuse	_____Liver disease	_____Ulcers
_____Emphysema	_____Low Blood Pressure	_____Venereal Disease
_____Epilepsy	_____Mitral Valve Prolapse	_____Yellow Jaundice
_____Fainting Spells	_____Osteoporosis	Other_____

Are you under the care of a physician at this time? _____Yes _____No
If so, what conditions?_____

Have you ever responded adversely to medical or dental treatment? _____Yes _____No
Are you currently taking any medication? Yes or No If yes, please list:

_____

_____

For Women:
Are you or do you suspect you are pregnant? Yes or No Are you nursing? Yes or No

To the best of my knowledge, the information given is accurate and complete. I understand that in order to provide the best dental care, it is my responsibility to inform this office of any changes in my patient information or medical information.

Patient (or Guardian) Signature: _____
Date:_____

Insurance Information

*Patient Name _____ Date:_____

*Policy holder's full name _____

*Policy holder's SSN _____*Date of Birth_____

*Insurance company _____

*Insurance company mailing address_____

_____

*Insurance company toll free #_____

*Policy holder's employer _____

*Policy holder's insurance ID# _____

*Group or Policy Number _____

*List family members on policy Date of Birth Relationship

_____

_____

_____

_____

Are any of these insured members covered by another dental insurance policy? _____

PLEASE READ: **Once your plan has been verified, we will submit claims to your insurance company for payment. Most plans only cover a portion of dental fees. You will be expected to pay any deductibles and unpaid portion at time of dental service.**

Your signature serves as an assignment of benefits for any insurance coverage and as a release of information to your dental insurance company. I understand and agree that I will be responsible for any balance not covered by insurance, to be paid in full within 30 days. In the event that my account is turned over to collection agency, I understand and agree I will be responsible for collection fees, attorney fees, court costs, etc. Any returned checks will be assessed a $25.00 fee.

***If there is no dental insurance, payment is due in full at the time services are rendered. _____**

***I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICES/FINANCIAL POLICIES STATED ABOVE.**

X_____ Date:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOT ICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

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

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA 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 HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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)_____

Signature of Privacy Officer_____