A Dental & Denture

Patient Information **Today's Date:** _____

Name: First _____ M. ____ Last _____

Nickname _____ Date of Birth _____/_____/_____ SSN# _____/_____/_____

Family Status: ☐ Minor ☐ Single ☐ Married ☐ _____ Gender: ☐ Male ☐ Female ☐ _____

Street Address _____City _____

State _____ Zip Code _____ Email _____

Cell Phone _____ Home Phone _____

Employer Name: _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Responsible Party: Self / _____ Phone _____ Relationship _____

Insurance Information (Skip if you have NO Insurance)

Name of Insured _____ Relationship _____

ID#/SSN#_____ Date of Birth _____

Insurance Name: _____ Insurance Tel. No. _____

Do you have any additional insurance? ☐ Yes ☐ No If Yes, Complete the following:

Name of Insured _____ Relationship _____

ID#/SSN#_____ Date of Birth _____

Insurance Name: _____ Insurance Tel. No. _____

Insurance Authorization:

I authorize my insurance company to pay A Dental & Denture all insurance benefits rendered.
I authorize A Dental & Denture to make use of my signature of file on all insurance submissions.
I authorize A Dental & Denture to submit pre-authorization on my treatment plan.
I authorize A Dental & Denture to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature _____

How did you hear about us? ☐ **Google** ☐ **Bing** ☐ **Yellow Pages** ☐ **Friend or Family**_____

☐ **Facebook** ☐ **Yelp** ☐ **Twitter** ☐ **Other:** _____

Financial Policy

If I do not pay the entire new balance within 60 days of monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $5 for a balance under $100) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or Responsible Party Signature_____ **Date** _____

PATIENT MEDICAL INFORMATION AND HISTORY

Patient Name: _____ Date: _____ /_____ /20_____

Have you had:

☐ Yes ☐ No AIDS / HIV Positive
☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Allergies
_____
☐ Yes ☐ No Alzheimer's Disease
☐ Yes ☐ No Anemia
☐ Yes ☐ No Angina
☐ Yes ☐ No Arthritis/Rheumatism
☐ Yes ☐ No Artificial Heart Valve
☐ Yes ☐ No Asthma/COPD
☐ Yes ☐ No Autoimmune Disease
☐ Yes ☐ No Back Problems
☐ Yes ☐ No Blood Disease
☐ Yes ☐ No Blood Thinners
☐ Yes ☐ No Cancer_____
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Circulation Problems
☐ Yes ☐ No Cortisone Treatments
☐ Yes ☐ No Cough, persistent
☐ Yes ☐ No Cough, up blood
☐ Yes ☐ No Depression
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Dizziness/ Fainting
☐ Yes ☐ No Easily Winded
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy/Convulsions
☐ Yes ☐ No Fainting
☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Frequently Tired
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Growth Tumors
☐ Yes ☐ No Headaches, frequent
☐ Yes ☐ No Headaches, migraines
☐ Yes ☐ No Head/Neck Injuries
☐ Yes ☐ No Heart Attack/Stroke
☐ Yes ☐ No Heart Disease-Surgery
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis A B C
☐ Yes ☐ No Herpes
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Implant Surgical
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Joint Replacement
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Leukemia
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Mental Disorders
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Nervous Disorders
☐ Yes ☐ No Pacemaker/Stents
☐ Yes ☐ No Parkinson's Disease
☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Respiratory Problems
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Seizure Disorders
☐ Yes ☐ No Shingles
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Sleep Apnea
☐ Yes ☐ No STD/HPV
☐ Yes ☐ No Stomach Troubles
☐ Yes ☐ No Swollen Ankle
☐ Yes ☐ No Thyroid Problem
☐ Yes ☐ No Tobacco Use
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcer Colitis

Do you have any disease, condition or problem not listed? _____

Females: ☐ Yes ☐ No Are you pregnant? (Due Date _____) ☐ Yes ☐ No Are you taking oral contraceptives (Birth Control Pills)?

_____ _____ _____
Medical Doctor's Name | Address/Clinic Name | Telephone No.

_____ _____ _____
Specialist Doctor's Name | Address/Clinic Name | Telephone No.

_____ _____
Date of Last Physical Examination: | Results

_____ _____ _____
Pharmacy Name | Address/Location | Telephone No.

Are you being treated by a medical doctor now? ☐ Yes ☐ No If yes, for what reason?

_____

Are you sensitive or have allergies to any medicine? ☐ Yes ☐ No If yes, what?

(Local Anesthetic) (Aspirin) (Penicillin) (Codeine) (Sulfa) (Iodine) (Latex) Other: _____

Have you ever been hospitalized or had any surgical operations? ☐ Yes ☐ No If yes, list reasons and dates

_____

List any medications you are currently taking:

_____

PATIENT DENTAL HISTORY

Patient Name: _____ Date: _____ /_____ /20_____

Check if you have had any problems with the following:

☐ Yes ☐ No Do you have any teeth that are hurting?
☐ Yes ☐ No Have you had any serious trouble associated with any previous dental treatment?

If yes, explain:

_____

_____

☐ Yes ☐ No Do you clench or grind your teeth?
☐ Yes ☐ No Have you ever received treatment for periodontal disease?
☐ Yes ☐ No Do you like the way your teeth look?
☐ Yes ☐ No Bad Breath
☐ Yes ☐ No Clicking or popping jaw when you chew: Left or Right
☐ Yes ☐ No Food trapped between teeth
☐ Yes ☐ No Loose Teeth
☐ Yes ☐ No Periodontal treatment
☐ Yes ☐ No Sensitivity to (cold) (hot) (sweets) (biting)
☐ Yes ☐ No Sores in mouth

Name of Previous Dentist:_____

Denture patients only:

Age of Denture/Partial: Upper _____ Lower _____
☐ Yes ☐ No Do you use adhesive on your dentures? Upper / Lower / Both
☐ Yes ☐ No Did you ever had your denture/partial relined? When? Upper:_____ Lower: _____
☐ Yes ☐ No Did you ever had your denture/partial repair?
What product or material do you use to clean your denture? _____

Name of Previous Dentist or Denturist who made your denture? _____

Authorization:

I have reviewed the information and answered all questions of my medical and dental history to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient or guardian: _____

Office use only:

Reviewed by: _____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES -HIPAA

Name of Patient (please print):_____ Date: _____

- I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of A Dental & Denture Associates, LLC.
- The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations.
- The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.
- The Statement of Privacy Practices is also posted in the facility.
- A Dental & Denture Associates, LLC reserves the right to change the privacy practices currently described in the Statement of Privacy Practices.
- If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective.
- I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

☐ YES ☐ NO - Spouse only
☐ YES ☐ NO - Any Member of my immediate family: (Spouse, Children, Children's Spouses)
☐ YES ☐ NO - Any Member of my extended family: (Parents, Grandchildren)
☐ YES ☐ NO - Other _____

Patient Signature (if 18 years old or older):_____

Patient's Personal Representative: (Please Print):_____

Personal Representative's Signature: _____

Representative's Telephone Number: _____

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

☐ YES ☐ NO Provided Prior to Treatment?

Date Statement Provided: _____

Reason for not obtaining patient signature

☐ Needed more time to review Statement of Privacy Practices
☐ Wanted to consult another person before signing
☐ Physically unable to sign
☐ No reason offered
☐ Other: