Promenade Center For Dentistry

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________

Patient Information

Patient Name ______________________________ Date ____________
Address ______________________________
City and State ______________________________ Zip ____________
Home Phone ____________ Work Phone ____________ Cell ____________
E-mail ______________________________
Patient SS# ______________________________ Date of Birth ____________
Patient's Employer ______________________________

Name of Spouse or Parent (if patient is a minor) ______________________________
Address (if different from above) ______________________________ SS# ____________
City and State ______________________________ Zip ____________
Home Phone ____________ Work Phone ____________ Cell ____________
Spouse or Parent's employer name ______________________________

In case of emergency, who shall we notify? ______________________________
Relationship? ______________________________ Phone ____________
How did you hear about our office? ______________________________

Person responsible for payment of this account ______________________________
***** Adult that brings in a minor child is responsible for payment on the day of service.**

TERMS AND CONDITIONS

In the event of a broken appointment, or a cancelled appointment with less than 2 business days notice, a fee may be applied to your account.

I understand payment or co-payment (insured patients) is due and payable in full at each appointment. In the event that this account becomes past due, the doctors, their assigns, or lawful agents may immediately consider the account in default and pursue collections procedures. If my account is past due I agree to pay 1.5% interest per month (15% annum) on unpaid balance from the date due, in addition to collection costs. Collection costs may include, but are not limited to court filing fees, service or processing costs and reasonable attorney fees of 30% of unpaid principle, or $50.00, whichever is greater. Any returned checks will be charged a processing fee of $25.00. I grant my permission to you or your assigns to telephone me at home or work to discuss matters related to this form.

Signature ______________________________ Date ____________

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Dental Insurance

Name of Insured ____

Insured Date of Birth ________________ Relationship to Patient ____________________

Insurance Co. ______________________________ Insured SS# ______________

Insurance Address ______________________________ Insured ID # ______________

______________________________ Group # ______________

Insurance Telephone ______________________________ Plan # ______________

Employer Name ____

Address ____

INSURANCE POLICIES

Our professional treatment is rendered to you, not your insurance company. You are responsible to us for the obligation of payment of treatment. Please understand that your insurance policy is a contract between you and your insurance company. Any problems of non-payment or delay of payment are your responsibility. Remember that dental benefits were never meant to determine your dental care; they are to assist you in the payment of your treatment choice.

Your are responsible for portions not covered by your policy on the day of service.

Any insurance balance over 60 days old is considered delinquent and is your responsibility to pay.

Please remember that we are not responsible for determining what your particular benefits are. Most policies cover what they consider "usual and customary" fee. However, the insurance company establishes these fees to meet their needs, and they are not always the same fees that may be charged in this office.

We will do our best to see that you receive the maximum benefit of your insurance. However, ultimate responsibility for payment is yours, and financial arrangements must be defined before dental treatment begins.

ASSIGNMENT OF BENEFITS
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed: ______________________

Date: ______________________

RELEASE OF INFORMATION
I authorize the release of any dental information necessary to process this claim.

Signed: ______________________

Date: ______________________

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Promenade Center for Dentistry

HIPAA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ ______________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  ____
- ☐ Other: ______________________________________

  ____

Prepared By ______________________________________

Signature ______________________________________

Date ______________________________________

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Promenade Center for Dentistry
Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth ______________

Promenade Center for Dentistry is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders Other______________________________
☐ Spouse (provide name and phone number) ____________________________________	☐ Financial ☐ Treatment Plans
☐ Parent (provide name and phone number) ☐ Other(i.e. Stepparent, Grandparent, Aunt, Uncle, Nanny etc) ---	☐ Financial ☐ Treatment Plans
☐ Email communication-Provide email address* __________________________________ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment Plans ☐ Appointment reminders ☐ Breach notification

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Patient Rights:
- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

____Date ___________________
Signature of Patient or Personal Representative
*Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014