Employee's Paylocity ID: _____

Patient Information

PERSONAL INFORMATION

Parent/Guardian: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐Unknown DOB: MM/DD/YY _____
Address: _____ City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ May we text you? ☐Yes ☐No

Patient Name: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐U DOB: MM/DD/YY _____
Patient Name: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐U DOB: MM/DD/YY _____
Patient Name: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐U DOB: MM/DD/YY _____
Patient Name: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐U DOB: MM/DD/YY _____
Patient Name: FIRST _____ MI _____ LAST _____ Sex: ☐M ☐F ☐U DOB: MM/DD/YY _____

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.

Employee's Paylocity ID: _____

Medical History

PERSONAL INFORMATION

Patient Name: FIRST _____ MI _____ LAST _____ DOB: MM/DD/YY _____

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 ☐ Cephalomitric 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: ☐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: _____

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 responsible 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 seguranza.

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: ☐M ☐F ☐D FDN: _____
Nombre del Paciente: _____ Género: ☐M ☐F ☐D FDN: _____
Nombre del Paciente: _____ Género: ☐M ☐F ☐D FDN: _____
Nombre del Paciente: _____ Género: ☐M ☐F ☐D FDN: _____
Nombre del Paciente: _____ Género: ☐M ☐F ☐D FDN: _____

CONFIDENTIAL COMMUNICATION REQUEST

Name of Patient _____ DOB _____
Name of Patient _____ DOB _____
Name of Patient _____ DOB _____
Name of Patient _____ DOB _____
Name of Patient _____ DOB _____

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 _____