

PRIMARY PHYSICIAN INFORMATION

Patient Name: _____ Date: _____

Physician: _____ Clinic/Facility: _____ Telephone: _____

MEDICAL HISTORY UPDATE

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

Y N Under a physician's care now?

Y N Any hospitalization in the past 5 years? _____

Y N Any serious illnesses/surgeries? _____

Y N Use tobacco in any form? If Yes, Type: _____

Y N Is pre-medication required before dental visits due to heart condition or artificial joint?

Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

Y N Do you snore?

Y N Have you ever been told you snore?

Y N Have you ever been diagnosed with Sleep Apnea?

Y N Do you ever wear a c-pap or any other device?

Y N Has anyone told you that you hold your breath while sleeping?

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y N
If yes, please describe: _____

Is there anything important about your medical condition we have not asked? Y N If yes, please describe: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> BULIMIA	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> PSYCHIATRIC TREATMENT
<input type="checkbox"/> ADHD	<input type="checkbox"/> CANCER/MALIGNANCY	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> RADIATION/CHEMO
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> CONVULSIONS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> STROKE
<input type="checkbox"/> ARTIFICIAL HEART VALVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> THYROID CONDITION
<input type="checkbox"/> ARTIFICIAL JOINTS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DIZZINESS/FAINTING	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> ULCERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> MONONUCLEOSIS	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> AUTISM/ASPERGER'S	<input type="checkbox"/> FREQUENT EAR INFECTIONS	<input type="checkbox"/> PACEMAKER	
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> OTHER – PLEASE LIST: _____	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> CODEINE	<input type="checkbox"/> LACTOSE INTOLERANCE	<input type="checkbox"/> SLEEPING PILLS	<input type="checkbox"/> NONE
<input type="checkbox"/> ANESTHETIC – LOCAL	<input type="checkbox"/> DAIRY	<input type="checkbox"/> METAL SENSITIVITY	<input type="checkbox"/> SULFA DRUGS	
<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> LATEX	<input type="checkbox"/> NITROUS OXIDE SEDATION	<input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS	
<input type="checkbox"/> OTHER – PLEASE LIST: _____				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | | |

PATIENT NAME:		DATE:
DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient Signature: _____

Dentist Signature: _____

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Delta Dental Premier.**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
 - o All major credit cards are accepted (Visa, MasterCard, Discover)
 - o Various financing options with CareCredit® and GreenSky
- **Balances left over 90 days will incur an 18% or \$10 minimum monthly finance charge unless prior financial arrangements have been made.**

Short Cancelled/ Missed Appointments

- **Please give 48-24 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** will be charged \$25 per hour.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Plaza Family Dental, Inc. (please check all that apply) :

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Cell phone: | <input type="checkbox"/> Text Message reminders permitted |
| <input type="checkbox"/> Home phone | <input type="checkbox"/> Work <input type="checkbox"/> E-Mail: |

I am granting permission for Plaza Family Dental, Inc. to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Plaza Family Dental, Inc. to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

- | | | | |
|---|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Work Phone | <input type="checkbox"/> None- please just ask for a call back |
| <input type="checkbox"/> Other (Please explain) | | | |

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other – please list:

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Plaza Family Dental, Inc. of the dental benefits otherwise payable to me.

I hereby authorize Plaza Family Dental, Inc. to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date: _____