VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

PATIENT INFORMATION

Patient Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female ◯ Rather Not Say

Address: _____

City: _____ State: _____ ZIP _____

Patient SS#: _____ Occupation: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Spouse's Name: _____ Birth Date: _____

SS#: _____ Occupation: _____

Employer: _____ Employer Phone: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

PHONE NUMBERS

Email: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to Valley Circle Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Valley Circle Family Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

MEDICATIONS

List Medications You Are Currently Taking:

_____

_____

_____

_____

_____

ALLERGIES

- ◯ Aspirin
- ◯ Barbiturates (Sleeping Pills)
- ◯ Codeine
- ◯ Iodine
- ◯ Latex
- ◯ Local Anesthetic
- ◯ Penicillin
- ◯ Sulfa
- ◯ Other _____

REASON FOR TODAY'S VISIT

_____

HEALTH HISTORY

Physician's Name: _____ Date of Last Visit: _____

Please Mark "Yes" or "No" To Indicate If You Have Had Any Of The Following:

AIDS	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Fainting or dizziness	◯ Yes	◯ No	Radiation Treatment	◯ Yes	◯ No
Arthritis, Rheumatism	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Respiratory Disease	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Artificial Joints	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Heart Problems	◯ Yes	◯ No	Shortness of Breath	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Bleeding Abnormally w/ Extractions or Surgery	◯ Yes	◯ No	Type _____			Skin Rash	◯ Yes	◯ No
			Herpes	◯ Yes	◯ No	Special Diet	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	HIV Positive	◯ Yes	◯ No	Swelling of Feet or Ankles	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No			
Chemotherapy	◯ Yes	◯ No	Jaw Pain	◯ Yes	◯ No	Swollen Neck Glands	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	Thyroid Problem	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cough, Persistent or Bloody	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tumor or Growth on Head or Neck	◯ Yes	◯ No
			Nervous Problems	◯ Yes	◯ No			
Diabetes	◯ Yes	◯ No	Pacemaker	◯ Yes	◯ No	Ulcer	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Women: Pregnant?	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
Contact Lenses	◯ Yes	◯ No	Nursing?	◯ Yes	◯ No	Unexplained Weight Loss	◯ Yes	◯ No
			Due Date _____					

Have you ever taken Fosamax (Bisphosphonate), Zometa, Actonel, Boniva or Aredia? ◯ Yes ◯ No

VALLEY CIRCLE
FAMILY DENTAL

Patient: _____

Date : _____

DENTAL HISTORY

Former Dentist: _____

City / State: _____

Date of Last Dental Visit: _____

Date of Last Dental X-Rays: _____

Please Mark "Yes" or "No" To Indicate If You Have Had Any Of The Following:

Bad Breath	◯ Yes	◯ No	Lip or Cheek Biting	◯ Yes	◯ No
Bleeding Gums	◯ Yes	◯ No	Loose Teeth or Broken Fillings	◯ Yes	◯ No
Blisters on lips / mouth	◯ Yes	◯ No	Mouth Breathing	◯ Yes	◯ No
Burning Sensation on Tongue	◯ Yes	◯ No	Mouth Pain, Brushing	◯ Yes	◯ No
Chew on One Side of Mouth	◯ Yes	◯ No	Orthodontic Treatment	◯ Yes	◯ No
Cigarette, Pipe or Cigar Smoking	◯ Yes	◯ No	Pain Around Ear	◯ Yes	◯ No
Clicking or Popping Jaw	◯ Yes	◯ No	Periodontal Treatment	◯ Yes	◯ No
Dry Mouth	◯ Yes	◯ No	Sensitivity to Cold	◯ Yes	◯ No
Fingernail Biting	◯ Yes	◯ No	Sensitivity to Hot	◯ Yes	◯ No
Food Collection Between the Teeth	◯ Yes	◯ No	Sensitivity to Sweets	◯ Yes	◯ No
Foreign Objects	◯ Yes	◯ No	Sensitivity when Biting	◯ Yes	◯ No
Grinding Teeth	◯ Yes	◯ No	Sores / Growths in Mouth	◯ Yes	◯ No
Gums Swollen or Tender	◯ Yes	◯ No	How Often Do You Floss?	_____	
Jaw Pain or Tiredness	◯ Yes	◯ No	How Often Do You Brush?	_____	

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 medications change, I will inform the dentist and the staff at the next appointment without fail.

_____ _____

Responsible Signature Date

TO BE FILLED IN BY DOCTOR

MEDICAL HISTORY REVIEWED ON: _____ BY _____

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

INFORMED CONSENT

X-RAYS & EXAMINATION

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while x-rays are taken on my teeth, that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant, radiation exposure poses a serious threat to the life and health of my unborn child. **Pregnant women are required to have a medical release from their medical doctor prior to having x-rays and/or dental treatment.**

_____
Initials

CHANGES IN TREATMENT PLANS

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that, whenever possible, I will be informed of any changes in advance. I give my permission to the dentist to make any changes and additions as necessary.

_____
Initials

DRUGS & MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

_____
Initials

I understand that there has been no guarantee or assurance made by anyone in regards to the dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.

Responsible Signature _____ Date _____

Doctor's Signature _____ Date _____

Witness' Signature _____ Date _____

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

OFFICE POLICIES

INSURANCE CARD ON FILE

We must have a copy of your insurance card (if applicable) and a photo ID (i.e. driver license, passport) on file.

_____
Initials

CANCELLATION AND RESCHEDULING

Unless an emergency comes up, we will always try to be prompt and we also appreciate you being prompt as well. If you need to reschedule an appointment, please notify us **at least 48 prior to your scheduled appointment time**. Failure to do so will result in a charge of $75.00 per hour scheduled.

_____
Initials

CONSENT FOR PAYMENT AND INSURANCE

CONSENT: I understand that all responsibility for payment for dental services provided in this office for any dependents or myself, is **due and payable at the times services are rendered**. Insurance coverage is only an estimate; the patient is responsible for all treatment costs not covered by insurance.

_____
Initials

SPECIALTY APPOINTMENTS

I understand that appointments with the specialist (Oral Surgeon, Periodontist or Endodontist) may require deposit.

_____
Initials

PAYMENT METHODS

For your convenience, we accept cash, Visa, Mastercard, American Express, Discover, and Care Credit.

_____
Initials

Please inform the office staff if you have any changes in your health, address, or insurance.

If you have any questions, please feel free to ask.

Printed Name _____ Date _____

Responsible Signature _____

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

HIPAA & NOTICE OF PRIVACY PRACTICES

PATIENT DETAILS

Patient's Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female ◯ Rather Not Say

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

HIPAA & NOTICE OF PRIVACY PRACTICES (CONT.)

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Patient: _____

Date : _____

HIPAA & NOTICE OF PRIVACY PRACTICES
(CONT.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENTS RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

VALLEY CIRCLE FAMILY DENTAL

Patient: _____

Date : _____

HIPAA & NOTICE OF PRIVACY PRACTICES (CONT.)

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

If patient is a minor, Guardian's relationship to patient: _____

Address: _____

City: _____ State: _____ ZIP _____

By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices

_____ _____

Responsible Signature Date