CITY DENTAL CLINIC

NEW PATIENT PAPERWORK PATIENT INFORMATION

Name:_____

LAST FIRST MI TITLE

Preferred Name:_____

☐ Male ☐ Female DOB:_____SSN:_____

Address:_____

City: _____State:_____ ZIP:_____

Cell Phone:_____Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

How did you hear about our office? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

■ Insurance – Primary ■

Subscriber Name:_____

Subscriber DOB:_____Subscriber SSN/ID: _____

Relationship: _____Insurance Phone:_____

Insurance Company Name: _____

CITY DENTAL CLINIC

MEDICAL HISTORY

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?

❑ Yes ❑ No

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one:_______________________________________

Do you take daily aspirin: ❑ Yes ❑ No

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list:____

Yes No Conditions

❑ ❑ Abnormal Bleeding
❑ ❑ Alcohol Abuse
❑ ❑ Anemia
❑ ❑ Angina Pectoris
❑ ❑ Anxiety
❑ ❑ Arthritis
❑ ❑ Artificial Heart Valve
❑ ❑ Artificial Joint
❑ ❑ Autism
❑ ❑ Auto Immune Conditions
❑ ❑ Asthma
❑ ❑ Back Problems
❑ ❑ Blood Transfusion .
❑ ❑ Cancer
❑ ❑ Chemotherapy
❑ ❑ Congenital Heart Defect
❑ ❑ Diabetes
❑ ❑ Difficulty Breathing
❑ ❑ Drug Abuse
❑ ❑ Epilepsy
❑ ❑ Fainting Spells
❑ ❑ Frequent Headaches
❑ ❑ Frequent Fainting

Yes No Conditions

❑ ❑ Glaucoma
❑ ❑ HIV+ AIDS
❑ ❑ Heart Attack
❑ ❑ Heart Murmur
❑ ❑ Heart Surgery
❑ ❑ Hemophilia
❑ ❑ Hepatitis A
❑ ❑ Hepatitis B
❑ ❑ Hepatitis C
❑ ❑ High Blood Pressure
❑ ❑ Joint Replacement
❑ ❑ Kidney Problems
❑ ❑ Liver Problems
❑ ❑ Low Blood Pressure
❑ ❑ Lupus
❑ ❑ Mitral Valve Prolapse
❑ ❑ Pace Maker
❑ ❑ Psychiatric Problems
❑ ❑ Radiation Therapy
❑ ❑ Respiratory Disease
❑ ❑ Rheumatic Fever
❑ ❑ Seizures
❑ ❑ Sexually Transmitted Disease

Yes No Conditions

❑ ❑ Shingles
❑ ❑ Sickle Cell Disease
❑ ❑ Sinus Problems
❑ ❑ Skin Rash
❑ ❑ Stroke
❑ ❑ Thyroid Problems
❑ ❑ Tuberculosis
❑ ❑ Ulcers

Allergies Yes No

❑ ❑ Aspirin
❑ ❑ Codeine
❑ ❑ Dental Anesthetics
❑ ❑ Latex
❑ ❑ Metals
❑ ❑ Penicillin
❑ ❑ Sulfa
❑ ❑

Other______________

If Female, Please Answer:

❑ ❑ Birth Control?
❑ ❑ Pregnant?
If so, # of Weeks________
❑ ❑ Are you nursing

CITY DENTAL CLINIC

DENTAL HISTORY

Your current dental health is: ❑ Good ❑ Fair ❑ Poor Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw? (TMJ) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No Do your gums bleed? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

How many times do you: floss/week?_____brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

How may we help you today?_____

When was your last dental cleaning?_____

When was your last dental visit? _____

Why did you leave your previous denist?_____

How can we accommodate you better during your dental visit?_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date: _____

CITY DENTAL CLINIC

CONSENTS

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

■ ASSIGNMENT AND RELEASE■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Reach 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 the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

■ CONSENT OF SERVICES ■

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required providing proper care. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service.

Signature:_____

Date:_____

CITY DENTAL CLINIC

CONSENTS

MISSED APPOINTMENTS We require that you call the office 24 hours in advance to cancel/reschedule your appointment. The Office reserves the right to charge for missed appointments. There is a $50 late cancellation/no show fee. If you miss an appointment without proper notice you will be charged this fee.

■ FINANCIAL AGREEMENT ■

For my convenience, this office may release my information to my insurance company, and receive payment directly from them. • I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. • I understand that Insurance is a form of payment, but the total bill is my responsibility. Any fees given are only estimate from your dental insurance company. • If sent to collections, I agree to pay all related fees and court costs. • Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. • Treatment plans may change and I will be responsible for the work actually done. • In case of a missed appointment or cancelled appointment (failing to inform office at least 24hrs in advance), you will be charged a $50 fee.

■ NOTICE OF PRIVACY POLICIES ■

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature:_____

Date:_____

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■ LATE SHOW APPOINTMENTS ■

If you are late to your appointment, we do not guarantee you will be seen. Your appointment may have to be rescheduled.

■ FINANCIAL AGREEMENT ■

For my convenience, this office may release my information to my insurance company, and receive payment directly from them. • I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. • I understand that Insurance is a form of payment, but the total bill is my responsibility. Any fees given are only estimate from your dental insurance company. • If sent to collections, I agree to pay all related fees and court costs. • Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. • Treatment plans may change and I will be responsible for the work actually done. • In case of a missed appointment or cancelled appointment (failing to inform office at least 24hrs in advance), you will be charged a $50 fee.

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Signature:_____

Date:_____

CITY DENTAL CLINIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/15/2013, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 change this Notice and provide the new Notice at our practice location, and we will distribute it 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.

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

Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information: We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: 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 your personal representative, but only if you agree that we may do so.