Today's Date: _____

Patient Information

Name: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____
Last First Mi

☐ Male ☐ Female

Birth Date: _____

Social Security #: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Mailing Address: _____
Street Apt #

_____
City State Zip Code

Physical Address: _____
☐ same as above Street Apt #

_____
City State Zip Code

Email Address: _____

Spouse, Parent/Guardian, Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment

Name: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____
Last First Mi

☐ Male ☐ Female

Birth Date: _____

Social Security #: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Mailing Address: _____
Street Apt #

_____
City State Zip Code

Physical Address: _____
☐ same as above Street Apt #

_____
City State Zip Code

Email Address: _____

Dental Insurance Information

(Please present insurance card to front desk)

Primary Insurance

Name of Dental Insurance: _____

Name of Policyholder: _____

Policyholder's Date of Birth: _____

Policyholder's ID # or SSN: _____

Name of Employer: _____

Policy/Group #: _____

Secondary Insurance

Name of Dental Insurance: _____

Name of Policyholder: _____

Policyholder's Date of Birth: _____

Policyholder's ID # or SSN: _____

Name of Employer: _____

Policy/Group #: _____

Referral Information

☐ Postcard ☐ Yellow Pages ☐ Letter ☐ Radio (96.7 or 106.3) ☐ Internet ☐ Word of Mouth ☐ Other: _____

Name of patient we may thank for referring you to our practice: _____

Name of dental office referring you to our practice: _____

Comprehensive Health History

Patient Name: _____ Date: _____

**It is important that we know about your Dental and Medical History. These facts may have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone.*

Thank you for taking the time to fill out this questionnaire completely.

Medical History

Are you currently under the care of a physician? _____ If yes, please explain: _____

_____

Name of physician(s): _____

Are you currently taking any prescription medications, OTC medications, or vitamins? _____ *

If yes, please list the name of ALL medications/vitamins, the reason you are taking them, and the prescribing doctor if applicable. Use the back of this sheet if necessary. If you have a list, please give it to the receptionist for a copy.

Medication:	Reason:	Prescribing Doctor:

Pharmacy: _____ City of Pharmacy: _____

Please check YES or NO for the following:	YES	NO
Are you currently taking prescription blood thinners?	☐	☐
Are you currently taking Aspirin daily? If so, circle your dose: 325mg or 81mg	☐	☐
Are you currently taking fish oil daily?	☐	☐
Women: Are you pregnant or currently breastfeeding? (Circle one)	☐	☐
Due date_____		
Have you ever taken Bisphosphonate medication for osteoporosis? (Brand names include Fosamax, Actonel, Atelvia, Didronel, Boniva)	☐	☐
Are you allergic to latex?	☐	☐
Are you allergic to penicillin?	☐	☐
Are you aware of being allergic to any other medications or substances?	☐	☐
If yes, please list: _____		
Are you currently taking sleep medication?	☐	☐
Do you currently smoke cigarettes?	☐	☐

Have you EVER had any of the following? Please check all that apply:

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis (Rheumatism)
- ☐ Artificial Heart Valve
- ☐ Artificial Hip
- ☐ Artificial Knee
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ Heart Problems (please describe)

  _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease or Malfunction
- ☐ Liver disease
- ☐ Material Allergies (latex, wool, metal, chemicals)
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Swelling of Feet and Ankle
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal Disease

Dental History

Reason for your visit today? _____

Approximately how long has it been since your last dental visit? _____

Please check YES or NO for the following:	**YES**	**NO**
Have you ever responded adversely to dental anesthetic?	☐	☐
If yes, please explain: _____		
Has a medical doctor ever told you that you must take antibiotics prior to dental treatment?	☐	☐
Do you wear dentures?	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about permanent replacements?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had any Periodontal (Gum) treatments?	☐	☐
Do your gums bleed, or feel tender or irritated?	☐	☐
Are your teeth sensitive to hot, cold, sweets, pressure? (circle all that apply)	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you ever worn braces?	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Do you regularly brush your teeth?	☐	☐
Do you regularly floss your teeth?	☐	☐

Please rank the following in order from 1-4 in which they would keep you from having dental treatment:

Fear of pain: _____ Cost of Treatment: _____ Lack of time: _____ Lack of concern: _____

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

CLEMENT
FAMILY DENTISTRY

OFFICE POLICY

WELCOME!
Thank you for choosing us as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Office Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FEE PAYMENT AND INSURANCE
Our practice is committed to providing the best treatment for our patients. As forms of payment, we accept cash, checks, MasterCard, Visa, Discover, and American Express. We have also partnered with Care Credit and Lending Club to offer you interest free financing or extended payment plans.

If you have dental insurance, we will assist you in every way to ensure that you receive your maximum benefits. It is your responsibility to pay for any and all dental services you receive that your insurance does not pay. If services are recommended that will not be covered by your insurance policy, these fees will be discussed with you.

On all accounts over 45 days, a late fee of $25.00 will be applied monthly. Coupons cannot be applied to previous balances.

WARRANTY
We will provide up to a one year warranty on most dental treatment. This is to be determined at the doctor's discretion. This warranty is automatically void if preventive appointments are not maintained every three to six months.

REFUNDS
There will be a 10% processing fee on check, cash, and credit card refunds that are requested after treatment has been accepted. There will be a 25% processing fee on Care Credit and Lending Club payment plans after treatment has been accepted. No refunds will be given after one year of service. Discounts and coupons are not redeemable for cash.

LATE CANCELLATIONS/BROKEN APPOINTMENTS
We understand that you are a busy person, and we are a busy office. If you reserve time, there is a commitment on your part to keep the appointment and a commitment on our part to provide you with the best care. We will call the day before your scheduled appointment as a courtesy reminder. If you need to reschedule your appointment, we ask that you give us a 24 hour notice. When you reserve an appointment, you reserve our time, our facilities, and our attention. Last minute cancellations (less than 24 hours) and broken appointments are disruptive to the schedule and other patients. There will be a charge of $50 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 24 hours notice. Emergency cancellations will be taken into consideration. Thank you for your cooperation.

I have read and understand the office polices stated above.

_____ _____

Signature of Patient/Responsible Party Date