PATIENT INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss ______________________________

Child/ Dependant: Yes ❑ No ❑

By what name do you prefer to be called? ______________________________

Birthday: ____________________ **Social Security No:** ____________________

Address: ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Mailing Address if different that above: ______________________________

Home Phone: ____________________ **Work Phone:** ____________________

Cellular Phone: ____________________ **Can We Text Message You:** Yes ❑ No ❑

E-mail Address: ______________________________

Name of Employer: ______________________________

If full time student, name of school: ______________________________

Emergency Contact Person: ______________________________

Relationship: ____________________ **Phone:** ____________________

How did you hear about our office: ______________________________

RESPONSIBLE PARTY INFORMATION

Name of person responsible for account: ______________________________

Birthday: ____________________ **Social Security No:** ____________________

Address/Phone (if different from above): ______________________________

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Name of Spouse: ______________________________

Birthday: ____________________ **Social Security No:** ____________________

Spouse's Employer: ______________________________

INSURANCE INFORMATION

Primary Insurance Company ____________________ **Effective Date:** __________

Subscriber Name: ____________________ **Employer:** __________

Social Security #: ____________________ **Birthdate:** __________

Group # / Policy #: ______________________________

Relationship to Patient: Self ❑ Spouse ❑ Child ❑ Other ❑ __________

Secondary Insurance Company ____________________ **Effective Date:** __________

Subscriber Name: ____________________ **Employer:** __________

Social Security #: ____________________ **Birthdate:** __________

Group # / Policy #: ______________________________

Relationship to Patient: Self ❑ Spouse ❑ Child ❑ Other ❑ __________

DENTAL

Are you in dental discomfort today?______________________________

Former Dentist: ____________________ Phone: ____________________

Date of last dental visit: ________________ Date of last x-rays: ________________

Please circle if you have had problems with any of the following:

Bad Breath	Food Collection Between Teeth	Periodontal Treatment
Bleeding Gums	Grinding or Clenching Teeth	Sensitivity to Hot or Cold
Clicking or Popping Jaw	Loose or Broken Teeth	Sores or growths

How often do you brush?________________ Floss? ________________

How do you feel about the appearance of your teeth? ____________________

MEDICAL

Physician Name:____________________ Phone:________________

Date of last Visit:________________ Have you had any serious Illness **or** Operation? ❒ **YES** ❒ **NO**

If **yes**, please explain: ______________________________

Women: Are you Pregnant? ❒ **YES** ❒ **NO** Nursing? ❒ **YES** ❒ **NO** Taking birth Control pills? ❒ **YES** ❒ **NO**

CIRCLE any of the following conditions you have or have had in the past:

AIDS/HIV Positive	Cortisone Treatment	Hepititis	Skin Rash
Anaphylaxis	Cough, Persistent	High Blood Pressure	Spinal Bifida
Anemia	Cough up Blood	Jaw Pain	Stroke
Arthritis, Rheumatism	Diabetes	Kidney Disease	Surgical Implant
Artificial heart Valve	Epilepsy	Liver Disease	Thyroid Disease
Artificial Joints	Fainting	Material Allergy (Latex/Metal)	Tobacco Habit
Asthma	Food Allergy	Mitral Valve Prolapse	Tonsillitis
Atopic (allergy prone)	Glaucoma	Nervous Problems	Tuberculosis
Back Problems	Headaches	Pacemaker/Heart Surgery	Ulcer/ Colitis
Blood Disease	Heart Murmur	Psychiatric care	Venereal Disease
Cancer	Heart Problems	Radiation Treatment	
Chemical Dependency	Hemophilia/Abnormal Bleeding	Respritory Disease	
Circulatory Problems	Herpes	Rheumatic/ Scarlet	

List any medications you are currently taking:____________________

List any drug allergies if any:____________________

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Dana Park Dental and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dana Park Dental and/or their trained staff to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists. Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.You, the patient/ responsible party, are ultimately responsible for payment in full on your account, not the insurance company. We do however; file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient/ responsible party. All delinquent accounts (30 days or older) are subject to reasonable service charges and/ legal interest rates. In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

____________________ ________________

Signature of Patient / Parent or Guardian **Date**

FINANCIAL AGREEMENT

Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.

INSURANCE FILING

You, the patient/ responsible party, are ultimately responsible for payment in full on your account, not the insurance company. We do however; file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient/ responsible party.

ASSIGNMENT OF INSURANCE BENEFITS

I/we hereby assign directly to Dana Park Dental Insurance Benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

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Responsible Party Signature

DELIQUENT ACCOUNTS

All delinquent accounts (30 days or older) are subject to reasonable service charges and/ legal interest rates.

COLLECTION PROCEEDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINMENTS

Failed appointments (less than 48 hours notice) are a significant contributor to rising health care costs. **Individuals who fail to show for a confirmed scheduled appointment will be assessed a fee based on the length of the missed appointment.**

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Responsible Party Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of this office's ***Notice of Privacy Practices.*** I further understand that I have the right to refuse to sign this acknowledgement.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

____

Responsible Party Signature

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW 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 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 must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 01*02*03, 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 anytime, provided such changes are permitted by applicable law. We reserve the right to make changed 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 make the notice available upon request. You may request a copy of our notice at anytime. For more information about our privacy practices, or for additional copies of these notice please contact using the information at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and 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 healthcare operation. Healthcare operation 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.
Your Authorization: In addition to our of your health information for treatment, payment, or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for anyone for any purpose. if you give us an authorization, you may revoke it in writing at anytime. 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 can not or 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 extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree 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, of your location, your general condition, or death. If you are present, then prior t 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 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 healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Market Health-Related services: we will not use your health information for marketing communication without written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible 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 safety of others.