

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. ☐ The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Please give 72 hours' notice to cancel or reschedule. A \$79 fee will apply if 72-hour notice is not given.

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Yes ☐ No

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

Have you experienced problems associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ☐ Yes ☐ No

If yes, what? _____

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you have mobility in your teeth? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ☐ Yes ☐ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No Date of last visit: _____

Physician's Name: _____

Address: _____ Phone #: (____) _____

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

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Have you been vaccinated for Covid-19? ☐ Yes ☐ No

If yes, type? _____ Date(s) _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other Bisphosphonate? ☐ Yes ☐ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Are you taking any of the following?

Y N Acetaminophen	Y N Aspirin	Y N Cold Remedies	Y N Nitroglycerin	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Thinners	Y N Digitalis/Heart Medication	Y N Recreational Drugs	Y N Tranquilizers
Y N Antihistamines	Y N Blood Pressure Medication	Y N Insulin/Diabetes Drugs	Y N Steroids/Cortisone	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Yes ☐ No If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Low Blood Pressure	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease
Y N Anemia	Y N Covid-19	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Arthritis	Y N Diabetes	Y N Heart Surgery	Y N Osteoporosis/Paget's Disease	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Difficulty Breathing	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Drug Abuse	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Emphysema	Y N Herpes	Y N Psychiatric Treatment	Y N Tonsillitis
Y N Autism	Y N Epilepsy	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Blood Transfusion	Y N Fainting Spells	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Cancer	Y N Fever Blisters	Y N Hospitalized for Any Reason	Y N Scarlet Fever	Y N Venereal Disease
Y N Chemotherapy	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	
Y N Chicken Pox	Y N Hay Fever	Y N Liver Disease		

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

Signature

Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature

Date

Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr I prefer to be called: _____ ☐ M ☐ F ☐ Non-binary

Birthdate: ____/____/____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Cell #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

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