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-h | our notice is |
| not given. | | |
| | | |
| This consent was signed by:(PRINT NAME PLEASE) | | |
| Signature: | Date: | |
| Witness | Date | |

| Why have you carrently in poin? Are you present behalf in you you are behalf in you you you have behalf in you you are behalf in you you you you you yo | DENTAL | FILS LURY |
|--|--|--|
| Are your carrently in point? Do you required antibiotic before dental treatment? If Yes No No No No No No No N | Why have you come to the dentist today? | Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No |
| De you require antification force detail bracheantifs Yes Ne Ne De you set provided treated associated with Yes Ne De you set of the requirement of profiled associated with Yes Ne De you set of the requirement of the re | | Have you ever had periodontal disease? □ Yes □ No |
| Do you so represented problems associated with any presents desired work? Yes No progression and the work of the year of the property of | Are you currently in pain? ☐ Yes ☐ No | Do you have mobility in your teeth? ☐ Yes ☐ No |
| Do you now on how you were experienced poin / disconflort in your jow joint (IMA / IMO)? From current details beath is: Good Fair Poor | Do you require antibiotics before dental treatment? | Are your teeth sensitive to heat, cold, or anything else? |
| Last Visit Dote: | any previous dental work? | |
| Year current dental heath is: Good Fair Floor | Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? | |
| Type of bristles on your toethbrush? Hard Medium Soft | Your current dental health is: ☐ Good ☐ Fair ☐ Poor | (Please Circle) |
| How long do you use a toothbrush before replacing iff Do you see anything in addition to your brush and floss? Yes No | the first term of the control of the | Why did you leave your previous dentist? |
| Are you happy with the way your smile looks? Yes No No If yes, what? Would you like fresher breath? Yes No No No No No No No N | | What did you like most & least about any dentist you have seen? |
| If not, what would you change? Would you like fresher breash? Yes No Whiter teesh? Yes No No Whiter teesh? Yes No No Whiter teesh? Yes No No No Whiter teesh? Yes No No No No No No No N | | AND THE RESIDENCE OF THE PROPERTY OF THE PROPE |
| Week Provided you like fresher breath? Yes No No No No No No No N | | The state of the s |
| Do you have a personal physician? Yes No Date of last visit: | | 40 |
| How you ever taken fosamax, or any other Bisphosphonate? Yes No No Physician's Name: | | |
| Physician's Name: Address: Phone #!: Order current physical health is: Good Fair Poor Poor | | THE RESIDENCE OF THE PARTY OF T |
| Address: | | |
| Y N Jewelly / Metals Y N Jewelly / | | |
| Are you currently under the care of a physician? Y | | Y N Barbiturates Y N Jewelry / Metals Y N Sulfa Drugs |
| Please explain: Have you been vaccinated for Covid-198 | | Y N Dental Anesthetics Y N Penicillin Y N Other |
| Hove you been vaccinated for Covid-198 | | Please list additional drugs/materials that cause allergic reactions: |
| Do you smoke or use tobacco in any other form? | Have you been vaccinated for Covid-19? ☐ Yes ☐ No | |
| Are you pregnant? Are you pregnant? Are you pregnant? Are you pregnant? Are you nursing? Y N Acetaminophen Y N Aspirin Y N Cold Remedies Y N N Nitroglycerin Y N Recreational Drugs Y N Recreational Drugs Y N Steroids/Cortisone Are you taking any of the following? Y N Anthibiotics Y N Blood Thinners Y N Steroids/Cortisone Do you or have you experienced the following? Y N Abnormal Bleeding Y N Collis Y N Headdaches Y N Headdaches Y N Low Blood Pressure Y N Singles Y N Alcohol Abuse Y N Congental Heart Defect Y N Heart Martan Y N Low Blood Pressure Y N Singles Y N Arthritis Y N Diabetes Y N Heart Martan Y N Collis Y N Heart Martan Y N Collis Y N Heart Martan Y N Collis Y N Heart Martan Y N Martin Valve Prolapse Y N Arthritis Y N Diabetes Y N Heart Martan Y N Martin Valve Prolapse Y N Arthritis Y N Diabetes Y N Heart Martan Y N Martin Valve Prolapse Y N Arthritis Y N Drug Abuse Y N Heart Martan Y N Expleyer Y N Authina Y N Expleyer Y N Heart Martan Y N Expleyer Y N Heart Martan Y N Expleyer Y N Heart Martan Y N Procemoker Y N Throad Problems Y N Authina Y N Expleyer Y N Expleyer Y N Heart Martan Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Heart Martan Y N Expleyer Y N Heart Martan Y N Expleyer Y N Heart Martan Y N Expleyer Y N Heart Martan Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Prolapse Y N Procemoker Y N Throad Problems Y N Martin Valve Y N Martin | | For Women: Are you taking birth control pills? |
| Are you taking any of the following? Y N Acetaminophen Y N Aspirin Y N Blood Thinners Y N Blood Thinners Y N Blood Thinners 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? Y N Abnormal Bleeding Y N Colifis Y N Congenital Heart Detect Y N Heard Murmur Y N Annownal Bleeding Y N Congenital Heart Detect Y N Heard Murmur Y N Annownal Bleeding Y N Congenital Heart Detect Y N Heard Murmur Y N Mittal Valve Prologue Y N Antificial Bones/Joints Y N Antificial Webs Y N Egiplepsy Y N Blood Transfusion Y N Egiplepsy Y N Blood Transfusion Y N Egiplepsy Y N High Blood Pressure Y N High Blood Pressure Y N Recreational Drugs Y N Schole Debugs Y N Programma Y N Mittal Valve Prologue Y N Schole Cell Disease Y N Antificial Webs Y N Heard Surgery Y N Programma Y N Epiplepsy Y N Antificial Webs Y N Heard Surgery Y N Programma Y N Epiplepsy Y N High Blood Pressure Y N Programma Y N Epiplepsy Y N High Blood Pressure Y N Programma Y N Epiplepsy Y N High Blood Pressure Y N Programma Y N Epiplepsy Y N High Blood Pressure Y N Programma Y N Epiplepsy Y N High Blood Pressure Y N Recreational Drugs Y N Scalar Fever Y N Concer Y N Fever Bilisters Y N High Blood Creasure Y N Scalar Fever Y N Concer Y N Recreational Drugs Y N Scalar Fever Y N Venereal Disease AUTHORIZATIONS I cartify that I am covered by I cartify that I am covered by I cartify that I am covered by I cartify that I am responsible for payment of 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 services and responsible for paying any co-payment and services endered and also responsible for paying any co-payment of benefits. I authorize the dental staff to perform the necessary dental services I may need. My meth | | Are you pregnant? |
| Y N Acetaminophen Y N Aspirin Y N Blood Thinners Y N Digatalis/Heart Medication Y N Recreational Drugs Y N Tranquilizers Y N Antibiotics 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 Low Blood Pressure Y N Stringles Y N Steroids/Cortisone Y N Stringles Y N Albhormal Bleeding Y N Collis Y N Headaches Y N Low Blood Pressure Y N Stringles Y N Headaches Y N Low Blood Pressure Y N Stringles Y N Stringles Y N Headaches Y N Low Blood Pressure Y N Stringles Y N Stringles Y N Headaches Y N Headaches Y N Low Blood Pressure Y N Stringles Y N String | | Week #: Are you nursing? ☐ Yes ☐ No |
| Y N Acetaminophen Y N Aspirin Y N Blood Thinners Y N Digitalis/Heart Medication Y N Steroids/Cortisone Y N Tranquilizers Y N Antihistaminas Y N Blood Pressure Medication Y N Insulin/Diabetes Drugs Y N Steroids/Cortisone Po you retain any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? □ Yes □ No If yes, please list each one: Do you retain you experienced the following? Y N Low Blood Pressure Y N Stingles Y N Steroids/Cortisone Y N Stingles Y N Headaches Y N Low Blood Pressure Y N Stingles Y N Stockle Cell Disease Y N Low Blood Pressure Y N Stingles Y N Stockle Cell Disease Y N Heart Mumor Y N Covid-19 Y N Heart Surgery Y N Osteoporosis/Raget's Y N Stockle Cell Disease Y N Antificial Bones/Zoints Y N Diffactly Breathing Y N Heart Surgery Y N Disease Y N Heart Surgery Y N Steroid Therapy Y N Antificial Valves Y N Drug Abuse Y N Heapthitis Y N Heapthitis Y N Becember Y N Thyroid Problems Y N Antificial Valves Y N Explication Y N Explication Y N Explication Y N Explication Y N Heapthitis Y N Heapthitis Y N Poschiatic Treatment Y N Toraillinis Y N Torailli | Are you taking any | of the following? |
| Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? \(\text{Y N Is level Blood Pressure} \) N Is serviced. Do you or have you experienced the following? | Y N Acetaminophen I Y N Aspirin I Y N Cold F | Remedies Y N Nitroglycerin Y N Thyroid Medicine |
| Do you or have you experienced the following? Y. N. Abnormal Bleeding Y. N. Coltis Y. N. Headaches Y. N. Abnormal Bleeding Y. N. Congenital Heart Defect Y. N. Heart Attack Y. N. Low Blood Pressure Y. N. Sickle Cell Disease Y. N. America Y. N. Covid-19 Y. N. Heart Attack Y. N. Loy Blood Pressure Y. N. Sickle Cell Disease Y. N. Arthrids Y. N. Didabetes Y. N. Heart Attack Y. N. Loy Blood Pressure Y. N. Sickle Cell Disease Y. N. Arthrids Y. N. Didabetes Y. N. Heart Attack Y. N. Loy Blood Pressure Y. N. Sickle Cell Disease Y. N. Arthrids Y. N. Didabetes Y. N. Heart Attack Y. N. Loy Blood Pressure Y. N. Sickle Cell Disease Y. N. Sickle Cell Disease Y. N. Arthrids Y. N. Didabetes Y. N. Heart Attack Y. N. Heart Attack Y. N. Loy Blood Pressure Y. N. Sickle Cell Disease | Y N Antibiotics Y N Blood Thinners Y N Digital | lis/Heart Medication Y N Recreational Drugs Y N Tranquilizers /Diabetes Drugs Y N Steroids/Cortisone |
| Do you or have you experienced the following? Y N Abnormal Bleeding Y N Colifis Y N Headaches Y N Love Blood Pressure Y N Singles Y N Alcohol Abuse Y N Congenital Heart Defect Y N Heart Attack Y N Lupus Y N Sixtle Cell Disease Y N Anemia Y N Covid-19 Y N Heart Murmur Y N Mitral Valve Prolapse Y N Sixtle Cell Disease Y N Arthrilis Y N Difficulty Breathing Y N Heart Murmur Y N Mitral Valve Prolapse Y N Sixtle Cell Disease Y N Arthrilis N N Difficulty Breathing Y N Heart Murmur Y N Mitral Valve Prolapse Y N Sixtle Frozens P N N Arthrilis N N Author Y N Exploses Y N Service Heart N N Stroke Y N Arthrilis N N N Difficulty Breathing Y N Heart Murmur Y N Mitral Valve Prolapse Y N Stroke P N N Arthrilis N N Author Y N Emphysema Y N Herpes Y N Pocemoker Y N Thyroid Problems Y N Autism Y N Epilepsy Y N Helph Blood Pressure Y N Psychiatric Treatment Y N Toberculosis (TB) Y N Chicken Pox Y N Fever Blisters Y N Hospatitized for Any Reason Y N Remarks (Fever Y N Memorated Prever Y N N Chicken Pox Y N Hay Fever Y N N Kidney Problems Y N Services Y N V N Services Y N N Services Y N V N N N N N N N N N N N N N N N N N | · · · · · · · · · · · · · · · · · · · | The second secon |
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| Y N Alcohol Abuse Y N Congenital Heart Defect Y N Heart Attack Y N Lupus Y N Mitral Valve Prolapse Y N Mitral Valve Prolapse Y N Stroke Y N Artificial Bones/Joints Y N Difficulty Breathing Y N Heart Murmur Y N Mitral Valve Prolapse Y N Stroke Y N Artificial Valves Y N Difficulty Breathing Y N Heart Murmur Y N Mitral Valve Prolapse Y N Stroke Y N Artificial Valves Y N Programment Y N Emphysema Y N Hepothis Y N Hepothis Y N Programment Y N Hepothis Y N Programment Y N Program | | |
| Y N Arthritis Y N Diabetes Y N Heart Surgery Y N Artificial Bones/Joints Y N Difficulty Breathing Y N Hemophilia Disease Y N Posemaker Y N Tryoid Problems Y N Asthma Y N Emphysema Y N Herpes Y N Herpes Y N Persistent Cough Y N Tonsillitis Y N Persistent Cough Y N Tonsillitis Y N Blood Transfusion Y N Epilepsy Y N Herpes Y N Herpes Y N Herpes Y N Paychiatric Treatment Y N Blood Transfusion Y N Fever Blisters Y N Concer Y N Claucoma Y N Hay Fever Y N Clicucoma Y N Kidney Problems Y N Storke Y N Stroke Y N Persistent Cough Y N Tonsillitis Y N Hospitalized for Any Reason Y N Rediction Treatment Y N Ucers Y N Stroke Y N Republic Treatment Y N Ucers Y N Stroke Y N Tonsillitis Y N Hospitalized for Any Reason Y N Rediction Treatment Y N Ucers Y N Stroke Y N Stroke Y N Tonsillitis Y N Hospitalized for Any Reason Y N Rediction Treatment Y N Ucers Y N Stroke Y N Tonsillitis Y N Hospitalized for Any Reason Y N Rediction Treatment Y N Ucers Y N Stroke Y N Tonsillitis Y N Tons | | |
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| Y N Asthma Y N Emphysema Y N Herpes Y N High Blood Fressure Y N Blood Transfusion Y N Fever Blisters Y N Concer Y N Fever Blisters Y N Hospitalized for Any Reason Y N Scarlet Fever Y N Chemotherapy Y N Glaucoma Y N Hay Fever Y N Chicken Pox Y N Hay Fever Y N Chicken Pox Y N Hay Fever Y N Liver Disease 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 PAYMENT IS DUE AT TIME OF SERVICE Our office is HIPAA compliant and is committed to meeting or exceeding the | | |
| Y N Autism Y N Epilepsy Y N High Blood Pressure Y N Psychiatric Treatment Y N Radiction Treatment Y N Ulcers Y N Concer Y N Chemotherapy Y N Glaucoma Y N Hay Fever Y N Chicken Pox Y N Hay Fever Y N Liver Disease Y N Liver Disease 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 PAYMENT IS DUE AT TIME OF SERVICE Our office is HIPAA compliant and is committed to meeting or exceeding the | Y N Artificial Valves Y N Drug Abuse Y N Hepi | atitis Y N Pacemaker Y N Thyroid Problems |
| Y N Blood Transfusion Y N Fainting Spells Y N HIV*/AIDS Y N Radiation Treatment Y N Rever Blisters Y N Chemotherapy Y N Chicken Pox Y N Hay Fever Y N Hay Fever Y N Liver Disease Please list any serious medical condition(s) that you have experienced: Laffirm 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 Date PAYMENT IS DUE AT TIME OF SERVICE | | |
| Y N Chicken Pox Y N Hay Fever Y N Liver Disease Y N Scarlet Fever Y N Seizures 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 | Y N Blood Transfusion Y N Fainting Spells Y N HIV | +/AIDS Y N Radiation Treatment Y N Ulcers |
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| 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 | Laffirm that the information I have given is correct to the best of | I certify that I am covered by Insurance Co. and |
| otherwise payable to me. I understand that I am responsible for payment of services and also responsible for 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. Signature PAYMENT IS DUE AT TIME OF SERVICE Our office is HIPAA compliant and is committed to meeting or exceeding the | | |
| deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. Signature PAYMENT IS DUE AT TIME OF SERVICE Our office is HIPAA compliant and is committed to meeting or exceeding the | | |
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| | | Signature Date |

FORM # A2C0197-vcovid

www.informsonline.com

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Welcome

ABOUT YOU

| Today's Date: | E-mail Address: |
|--|--|
| Name: Lost First Mi Mr Mrs Ms Dr | I prefer to be called: |
| Birthdate:// Age: Social Security #: | D. Single D. Married D. Diversed D. Widewed D. Separates |
| | a single a Married a Divorced a Widowed a separate |
| Home Address: | City State Zip |
| | |
| Where & when are best times to reach you? Whom may | |
| Other family members seen by us: How long there | |
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| Employer's Address:Street/PO Box | City State Zip |
| Neighbor or Relative not | |
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| Address:Street | City State Zip |
| Person Responsible for Account i | f other than yourself |
| | #: Social Security #: |
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| SPOUSE INFOR His / Her Name: Bir Employer: Work Phone #: INSURANCE INFO Primary Insurance Dental Coverage? □ Yes □ No Medical Coverage? □ Yes □ | MATION hdate:/ Social Security #: Ext: Drivers License #: PRMATION Yes □ No Orthodontic Coverage? □ Yes □ No |
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