



NEW PATIENT DENTAL INTAKE FORM

Patient Information:

Legal and preferred name: _____ Date of birth: _____

Address: _____

Phone number: _____ Email: _____

Sex/Gender

- Male
- Female
- Other (please specify): _____

Employer or School: _____

Emergency contact: _____

Relationship to you: _____ Phone number: _____

Dental Insurance:

Insurance Company: _____ Phone Number: _____

Subscribers Member ID: _____ Group Number: _____

Address: _____

Name of Subscriber: _____

Employer offering this insurance: _____

Address: _____

Dental History:

Reason for today's visit: _____

Date and reason for last dental visit: _____

Please check if you have any of the following conditions:

- | | |
|---|--|
| <input type="radio"/> Bad breath | <input type="radio"/> Loose or broken teeth |
| <input type="radio"/> Bleeding gums | <input type="radio"/> Sensitivity when biting or chewing |
| <input type="radio"/> Pain when flossing | <input type="radio"/> Sensitivity to cold, hot or sweets |
| <input type="radio"/> Clicking or popping jaw | <input type="radio"/> Mouth sores |
| <input type="radio"/> Teeth grinding | <input type="radio"/> Missing teeth |

Is there anything about the appearance or function of your teeth that you'd like to address?



Medical History:

Physician: _____ Date of last visit: _____

Please describe any serious illnesses or operations you've had: _____

Please check if you've had any of the following and the date of surgery:

- Knee replacement or surgery
- Hip replacement or surgery
- Pacemaker placement
- Heart surgery

Women:

Are you pregnant or nursing? _____

Are you taking birth control? (please specify) _____

Please check if you have or have had any of the following:

- | | | |
|---|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Heart murmur | <input type="radio"/> Radiation treatment |
| <input type="radio"/> Arthritis, rheumatism | <input type="radio"/> Heart problems | <input type="radio"/> Respiratory disease |
| <input type="radio"/> Asthma | <input type="radio"/> Hemophilia | <input type="radio"/> Stroke |
| <input type="radio"/> Abnormal bleeding | <input type="radio"/> Hepatitis | <input type="radio"/> Tobacco use |
| <input type="radio"/> Blood disease | <input type="radio"/> High blood pressure | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cancer | <input type="radio"/> HIV/AIDS | <input type="radio"/> Other: _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Kidney disease | |
| <input type="radio"/> Drug dependency | <input type="radio"/> Liver disease | |
| <input type="radio"/> Epilepsy | <input type="radio"/> Migraines | |
| <input type="radio"/> Glaucoma | <input type="radio"/> Mitral valve prolapse | |

Please list any medications you are currently taking and the correlating diagnosis (please provide pre-made list if more space is needed):

Please list any allergies you may have:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

Patient or Guardian Signature

Date:



HIPAA & Notice of Privacy Practices

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: <https://www.hhs.gov/hipaa/for-individuals/index.html>. We are required by law to maintain the privacy of your health information and to provide you with this notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time. 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 make reasonable efforts to change this notice and make the new notice available 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.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our 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 health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally 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 the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved in Your 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, concerning your location, your general condition, or death. If you are present, then prior to 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 (1) 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 health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your 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 may be a 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 or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.



Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please contact us to make these arrangements.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

If patient is a minor,

Guardian's relationship to patient:

Address:

City:

State:

Zip Code:

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Patient Signature: _____

Date: ____/____/____



OFFICE POLICY

We have a 48-hour cancellation notice on any appointment(s). We understand that situations may arise that don't allow you to make changes to your appointment within the 48-hour window, but please try to contact us during business hours to make changes to your appointment(s). If there is more than one missed appointment without notice, a \$75 charge will be incurred to your account.

FINANCIAL POLICY

All payments are due at the time of service unless prior arrangements have been made. As a courtesy, all patients without dental insurance receive a 25% discount when payment is made in full. We are in-network with most PPO plans and are happy to submit to your insurance(s) on your behalf. However, copays are due at the time of service unless prior arrangements are made. If we are billing to your insurance, please know that this is a courtesy, it is your responsibility to research the coverage and limitations of your dental insurance. If you have any questions or concerns, please feel free to contact our office. We will do our best to maximize your insurance plan(s).

I have read and understand the office and financial policy. I understand that I am financially responsible for services rendered in the office.

Patient or Guardian Signature

Date