PATIENT INFORMATION (CONFIDENTIAL)

NAME: ______________________________ DATE: ______________
FIRST MI LAST

ADDRESS________________________ CITY__________ STATE/ PROV______ ZIP/ P.C.________

EMAIL______________________________

CELL PHONE____________________ HOME PHONE____________________

SS#/SIN____________________ BIRTHDATE: ____________________

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

SPOUSE OR PARENT'S/GUARDIAN'S NAME ______________________________

EMPLOYER____________________ WORK PHONE____________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PERSON TO CONTACT IN CASE OF EMERGENCY______________________________

EMERGENCY CONTACT PHONE #______________________________

RESPONSIBLE PARTY CHECK BOX IF YOU (PATIENT) ARE THE RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCT: ______________________________

RELATIONSHIP TO PATIENT:____________________

ADDRESS:______________________________

HOME PHONE# ____________________ CELL PHONE #____________________

SS#/SIN ____________________

EMPLOYER____________________ WORK PHONE____________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

PATIENT'S NAME ______________________ **DATE OF BIRTH** ______________________

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
ARE YOU IN GOOD HEALTH	☐	☐
HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐

IF SO WHAT CHANGES ______________________

____

PHYSICIAN'S NAME ______________________

PHONE NO. ______________________

	YES	NO
ARE YOU UNDER THE CARE OF A PHYSICIAN	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS.	☐	☐

PLEASE EXPLAIN ______________________

____

	YES	NO
ARE YOU TAKING ANY MEDICINE(S).	☐	☐

IF YES, WHAT MEDICINE(S) ARE YOU TAKING ______________________

____

	YES	NO
HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
DO YOU BRUISE EASILY	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES, SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS(E.G, NICKEL, MERCURY, ECT)	☐	☐
LATEX/RUBBER	☐	☐

OTHER (PLEASE LIST) ______________________

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
RHEUMATIC HEART DISEASE/FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐

	YES	NO
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
DO YOU USE TOBACCO	☐	☐
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS(LASTING MORE THAN 3 WEEKS)	☐	☐
DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT.	☐	☐

WOMEN ONLY:

	YES	NO
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐

	YES	NO		YES	NO
HEART SURGERY	☐	☐	TUMORS	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐	MENTAL HEALTH CARE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐	BACK PROBLEMS	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐	CHEMICAL DEPENDENCY	☐	☐
HEPATITIS, JAUNDICE, OR LIVER DISEASE	☐	☐	MITRAL VALVE PROLAPSE	☐	☐
STROKE	☐	☐	CORTISONE TREATMENT	☐	☐
SINUS TROUBLE	☐	☐	COLD SORES/FEVER BLISTERS	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐	HYPOGLYCEMIA	☐	☐
ASTHMA OR HAY FEVER	☐	☐	EATING DISORDERS	☐	☐

DENTAL HISTORY

REASON FOR THIS VISIT ______________________________

WHEN WAS YOUR LAST DENTAL VISIT ______________ WHAT WAS DONE THEN ______________

DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING . . . ☐ ☐

ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS . . . ☐ ☐

DO YOU FEEL PAIN TO ANY OF YOUR TEETH . . . ☐ ☐

IF YES, FOR HOW LONG HAS THIS BEEN GOING ON FOR? ______________

HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS . . . ☐ ☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________

____

____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PLEASE BE ADVISED FOR DOCTOR TO PROPERLY DIAGNOSE AND MONITOR YOUR ORAL DENTAL HEALTH RADIOGRAPHS ARE NEEDED. SOME PATIENTS ARE AT MORE RISK FOR CARIES DEVELOPMENT, PERIODIC X-RAYS ARE NEEDED TO DIAGNOSE AND MONITOR THE CONDITION. PLEASE INFORM THE OFFICE OF ANY RECENT X-RAYS COMPLETED AT ANOTHER DENTIST OFFICE.

PLEASE REVIEW REGISTRATION PAPERWORK AND FILL OUT TO THE BEST OF YOUR KNOWLEDGE. ALL PAPERWORK REMAINS CONFIDENTIAL AND WE FOLLOW HIPAA REGULATIONS. THANK YOU FOR BEING OUR VALUED PATIENT HERE AT FIT DENTAL. PLEASE SIGN BELOW.

______________________________ ______________________

PATIENT/GUARDIAN SIGNATURE Date

CONSENT FORMS

Patient Name: ___________________________________ **DOB**:_________________

Insurance Benefits:

Each insurance company offers several different insurance plans to their clients. Each of these insurance packages offer widely varying benefits, depending on the cost that the employer has available for that purpose. The "UCR" benefits you receive are based on a fee structure chosen by the insurance company for the package that your employer has selected. These fee schedules are not always a true reflection of what is a "usual and customary rate" in terms of our demographic area or the quality of dentistry we provide. Because of numerous plans and different fee schedules, we can only estimate your expected coverage. Keep in mind that insurance estimates are estimates only. Treatment fees are estimates and could be altered if your dental needs change. It will be our pleasure to assist you in maximizing your insurance benefits. Please advise us of any dental benefits used elsewhere. We will make every effort to discover the approximate amount your insurance will cover per procedure and bill your insurance company as a courtesy to you. Ultimately, however, you are responsible for all payment of treatment provided, regardless of any insurance involvement.

H.I.P.A.A:

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

· Conduct, plan and direct 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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my privacy 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 reactions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I acknowledge that I received from Fit Dental a copy of the Dental Materials Fact Sheet

CANCELLATION/NO SHOW POLICY:

Fit Dental requires a 48 business hours notice to cancel any appointments. The first cancellation made within the 48 business hour period will incur a charge of $50 and the second cancellation will incur a charge of $75 for basic services such as cleanings. If your appointment exceeds more than 60 minutes the cancellation/failed appointment fee will be $200 or higher depending on the amount of procedure time you are scheduled for.

____

Patient Signature Date