- **Patient Information:**

Patient Name: ____ Preferred Name: _________________________________

Birth Date: ______________________ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y - N

SS#: ____ Driver's License #: ______________________________________

Address: _______________________________________ City: ____________________ State: _______ Zip: ____________

Home Phone #: _____________________ Work #: _____________________ Cell #: _____________________________

Emergency Contact: __________________________________ Phone #: ____

Patient
E-mail address: ______________________________________ Best way to reach you: ____________________________

Employer: ____

Other family members seen by us: ____

How did you hear of us? ____

If referred by someone, whom may we thank for the referral? ____

- **Parent/Guardian Information (if patient is a minor):**

Name: ____ Relationship to patient: _______________________

Birth Date: _________________ SS#: ___________________________ Driver's License #: _________________________

Address: _____________________________________ City: _______________________ State: ______ Zip: ___________

Home Phone #: _____________________ Work #: ________________________ Cell #: ____________________________

- **Dental Insurance Information (Primary):**

Policyholder's Name: ____ Birth Date: _____________________

Patient's Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____ SS#: ______________________

Insurance Company: ____ Phone #: _______________________

Group #: ________________________________ Policyholder's ID#: ____

- **Consent for Services:**

As a condition of treatment by this office, ***all financial arrangements must be made in advance***. The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment. All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service. Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. ***It is our office policy to collect patient's estimated portion at the time of service.*** In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

I ____have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

Signature: X____ Date: X_________________________

- **Missed appointments/Short notice cancellations**

Without 48 hours advance notice, there will be a fee of $75 for any missed appointment. The missed appointment fee must be paid prior to future office visits. ________ (please initial). This clause would apply to patients that repeatedly occur into this offense.

Signature: X____ Date: X___________________________

- **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT 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 April 14, 2012, 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 any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. You may contact us to request more information about our privacy practices.

- **USES AND DISCLOSURES OF HEALTH INFORMATION:**

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

Signature: X____ Date: X_________________________

- **HIPAA COMPLIANCE:**

In compliance with the Federal HIPAA policy we are requesting your permission to send out appointment reminders via postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office. I give Strong Roots Dental permission to send appointment reminders via postcards.

Signature: X____ Date: X___________________________

- **Dental History:**

Are you currently in pain? Y - N Do your gums bleed? Y - N Do you like your smile? Y - N
What, if anything, would you change about your smile? ____
Why have you come to the dentist today? ____
How many times a day do you brush? _______ Have you ever had problems with previous dental treatment? Y - N
If yes, please explain: ______________________________
Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Y - N
Have you ever had a serious head, neck, or back injury? Y - N ____
Previous Dentist or Dental Office: _________________________________ When was last dental visit? ______________
Do you smoke or use chewing tobacco? Y - N If Yes, For How long and How Often? ______________________

- **Medical History:**

Physician's Name: ____ Phone #: _________________________________

WOMEN: Are you or could you be pregnant? Y - N Are you nursing? Y - N

Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:

☐Rheumatic Fever ☐Epilepsy/Seizures ☐Asthma ☐Hepatitis ☐Low Blood Pressure ☐Heart Murmur
☐Thyroid problems ☐Psychiatric Care ☐HIV/AIDS ☐Glaucoma ☐High Blood Pressure ☐Sinus Problems Mitral
☐Valve Prolapse ☐Implant/Transplant ☐Arthritis ☐Pacemaker ☐Blood Transfusion ☐Heart Surgery
☐Heart Attack/Stroke ☐Cancer/Chemo ☐Autism ☐Tuberculosis ☐Drug/Alcohol Abuse
☐Artificial Valve/Joint ☐Kidney Problems ☐Diabetes ☐Headaches ☐Excessive Bleeding
Please list any medical condition not listed above: ____

- **Allergies:**

Are you allergic to any of the following? PLEASE CIRCLE YES or NO FOR EACH ONE.
Latex Y - N Aspirin Y - N Penicillin Y - N Tylenol Y - N Erythromycin Y - N
Sulfa Y - N Codeine Y - N Ibuprofen Y - N Tetracycline Y N Dental Anesthetics Y N

Other ____

Please list all medications you are currently taking: ____

____
____

I __________________________________understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: X____

Parent/Guardian Signature if patient is a minor: X____

Date: X_______________________

DENTAL CONSENT FORM

Please read and initial items checked below and read and sign the section at the bottom of form.

Patient Name ____

1. DIAGNOSTIC AND_PREVENTIVE. I understand that I am having the following work done: x-rays, exam and cleaning
(Initials_____________________)

2. DRUGS AND MEDICATIONS. I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
Initials (_____________________)

3. LOCAL ANESTHETIC. I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain; numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.
Initials_____________________)

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient or legal guardian: X:______________________ **Date X:**______________________