Gentle Smiles
FAMILY DENTISTRY

Patient Last Name: ______________________ First: __________________ MI: _______ D.O.B ___/___/___

Insurance/Medicaid/Chip ID #: ________________________ □ Male □ Female □ Married □ Single □ Child □ Other

Phone (Hm) (___)________ (cell) (___)________ (wk) (___)________ Occupation: ____________________

Address: ____ Apt.# ____________________

City: _______________ ST: _______ Zip Code: ___________ E-Mail: __________________________________

Pharmacy Name: __________________________________ Location: ___________________________________

Phone Number: (_____) ____________________________ Fax Number: (______) ________________________

Are you now under the care of a physician? □ Yes □ No
If yes, please explain: ____

Name of Physician: ________________________________ Phone: ____________________ Fax: ________________

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

□ Rheumatic Fever
□ Heart Disease
□ Heart Murmur
□ Stroke
□ High Blood Pressure
□ Prolonged Bleeding
□ Hepatitis/Jaundice
□ Kidney/Renal Disease
□ Diabetes
□ Respiratory Problems
□ Asthma/Sinus Problems

□ Tuberculosis
□ Emphysema
□ Venereal Disease
□ HIV/AIDS
□ Epileptic Seizures
□ Allergies
□ Arthritis
□ Valve Replacement
□ Thyroid Problems
□ Joint Replacement
□Anemia/Blood Problem

□ Dizziness/Fainting
□ Mental/Nervous Disorder
□ Ulcers/Stomach Problems
□ Cancer / Tumors
□ Glaucoma
□ Pacemaker
□ Head Injuries
□ Rheumatism
□ Cholesterol
□ Birth Control
□ Pregnant? months: _____

□ Alcohol
How Often? ________
□ Tobacco, Smoking
How Often? ________
□ Recreational Drugs
□ Steroids
□ Codeine Allergy
□ Penicillin Allergy
□ Latex Allergy
□ Other: ____________
____

Are you allergic to any medications or drugs? If yes, please explain: ______________________________________
____

Are you taking any medication or pills? (Prescribed and Non-Prescribed): ___________________________________
____

Have you been admitted to a hospital or needed emergency care during the past five years? □ Yes □ No
If yes, please explain: ____

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: ____

◊ Reason for today's visit: ____

◊ Date of last dental visit: ______________________________ ◊ Date of last X-rays: ______________________

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or other staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

X____ Date: _____/_____/_____
Signature of patient (*** If under 18, parent or guardian must sign ***)

Gentle Smiles
FAMILY DENTISTRY

Patient name: ______________________________________ Date of Birth: ___/___/___

Patient Preference Regarding Communications of Health Information

***If the patient is under age 18 and you are not the parent of the patient, please provide legal documentation stating that you are the legal guardian of this patient and are able to make decisions regarding the patient.**

WHO TO CONTACT
I hereby give permission to Gentle Smiles, P.A. and staff to disclose and discuss any information related to my/my child's dental/Medical/Personal condition to/with the following family member(s), other relative(s), and/or close personal friend(s).

Name	Relationship	Date of Birth	Phone Number
Name	Relationship	Date of Birth	Phone Number
Name	Relationship	Date of Birth	Phone Number

_______ I do hereby give permission for any of the family members listed above to make decisions regarding my
(Initial) child's Dental/Medical/Personal treatment and bring my child to the dental office for treatment.

_______ I do **not** wish to give permission for any family members, relatives, or close personal friends to have
(Initial) access to any information regarding my/my child's Dental/Medical/Personal condition(s); or bring them to the dental office

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for Dental/Medical/Personal information from persons not listed above will require specific authorization prior to the disclosure of any Dental information.

X
Signature of Patient/Legal Representative/Guardian Date

PATIENT CONSENT FORM FOR HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protested health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right of review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ____

Print Parent/Guardian Name: ____

Relationship to Patient: ____

Signature:______________________________________ **Date:** ____________________

Dear Patient,
It is important to understand that this is a private practice. We are committed to providing you with the best possible care, and as such, this office continues to operate on the fees charged for dental services. It must be noted that all patients are ultimately responsible for all fees charged. Your clear understanding of our financial policy is important to our professional relationship.

Insurance

For those who have dental insurance, it is important to understand that actual benefit coverage varies depending on the individual insurance policy. The amount of the fees not covered by the insurance company is known as the **Co-Payment. All Co-Payments are expected at the time of services.**

As a courtesy, we will be happy to help you determine coverage you have available. We estimate as closely as possible your co-payments; however, your insurance is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept the responsibility of negotiating claims with insurance companies or other persons. If your insurance company pays only a portion of the bill or rejects your claim, you are responsible for full payment for services rendered.

Again all patients are ultimately responsible for all fees charged. If you refuse to pay your responsible amount, we reserve the right to send you to a collection agency.

If you are unable to keep your appointment, you must cancel within 24 hours or you will be charged a $25.00 fee. Please help us serve you better by keeping scheduled appointments.

Responsible Party Signature:____**Date:** ____________________