Shore Points General and Implant Dentistry

Welcomes you to their Practice!

Please help us by completing this form in ink. If you need assistance, please ask. **Thank You!**

PATIENT INFORMATION

Last name_____ **First**_____ **Middle**_____ **Preferred Name**_____

Age_____ Birth date____/____/____ Social Security #_____-_____-_____ Email Address_____

Mailing Address_____ City_____ State_____ Zip _____

Cell phone (____) _____-_____ Home phone (____)_____-_____ Office phone (____)_____-_____

Circle appropriate (Dr. / Mr. / Mrs. / Ms.) (Minor / Single / Married) Spouse name_____

Emergency Contact _____ Emergency Phone (____) ____-_____

How did you learn of our office? _____

BILLING INFORMATION

Name_____ Birth date____/____/____ Relationship_____ Soc sec #_____-_____-_____

Cell phone (____)____-_____ Home phone (____)____-_____ Email_____ Employer_____

Billing city_____ State _____ Zip_____

DENTAL INSURANCE INFORMATION

Primary:

Subscriber _____

Relationship_____ birth date ____/____/_____

Employer/union_____ emplr ph#(____)____-_____

Ins company_____

Group#_____ S.S/ID#_____

Secondary:

Subscriber _____

Relationship_____ birth date ____/____/_____

Employer/union_____ emplr ph#(____)____-_____

Ins company_____

Group#_____ S.S/ID#_____

AUTHORIZATION AND CONSENT

Please read and **initial** each of the following, and then **sign** below where indicated.

_____ I understand that minimum notice of one full business day is required to change an appointment, two full business days for a prime-time evening appointment, otherwise, a cancellation fee of $50 per hour scheduled may be charged.

_____ I authorize necessary dental services to be provided for my dependents and me with my informed consent during diagnosis and treatment.

_____ I authorize: The release of information relating to my dental care to third party payers and other health professionals; For this office to request and/or appeal claim determinations from my carrier; For my insurance company to pay directly to the dentist benefits otherwise payable to me

_____ I understand: That my insurance is a contract between me and my carrier: That I am responsible for knowing the benefits and limitations of my policy; That insurance estimates are provided as a courtesy only; That my insurance may pay less than the actual bill for services or estimated insurance payments; And I am responsible for the payments for all services rendered on behalf of my dependents and me.

_____ I understand: That full payment is due at or before each appointment: Any payment discussion must be done prior to delivery of services; That a (1.25% (15% APR) monthly fin./rebilling charge (min. $4.25) may apply to any balance on account after 30 days; That failure to keep my account current will result in denial of additional dental services except for emergencies and where pre-payment is made.

_____ In case of default, I understand that I end my patient/doctor relationship, that collection expenses may be added to my account, and that my account may be reported to a credit bureau.

I have read and agree to the above conditions of treatment and payment.

Signature Date / /

MEDICAL HISTORY

Name _____ **Birthdate** ____/____/_____

Medical Dr. _____

Medications: Are you taking any medications – including non-prescription? ... ***Yes \ No***

If yes, please list below or attach a list to this form.

_____

_____

_____

_____

_____

Pre-medicate: Have you been told you need antibiotics *before* dental work? .....**Yes \ No**

Allergies: Are you allergic to, or had reactions to any of the following?

Yes \ No – penicillin/antibiotics

Yes \ No – novacaine/anesthetics

Yes \ No - **Other** – *If yes, please list.* _____

_____

Health Conditions: Do you have, or have you had in the past, any of the following?

Yes \ No – heart trouble	***Yes \ No*** – **High Blood Pressure**	***Yes \ No*** –**Osteoporosis/Bisphosphates**
Yes \ No – breathing trouble	***Yes \ No*** – head / neck / face pain	***Yes \ No*** – thyroid condition
Yes \ No – kidney disease	***Yes \ No*** – liver disease	***Yes \ No*** – STD, AIDS or HIV
Yes \ No – hepatitis	***Yes \ No*** – diabetes	
Yes \ No – cancer / leukemia	***Yes \ No*** – seizures/epilepsy	For Woman Only: Are you...
Yes \ No – pacemaker/defibrillator	***Yes \ No*** – heart murmur/ MVP	***Yes \ No \ Maybe*** – pregnant?
Yes \ No – **heart valve surgery**	***Yes \ No*** – drug / alcohol problem	***Yes \ No*** – breast feeding?
Yes \ No – **joint replacement**	***Yes \ No*** – smoke / chew tobacco	***Yes \ No*** – using birth control?

Is there anything else we should know about your health?..... ***Yes \ No***

If yes, please explain. _____

_____

_____

By my signature below, I certify that the above information is complete and accurate.

Patient's / Guardian's

Signature X _____ ***Date*** ____/____/_____

FOR OFFICE USE **** MEDICAL ALERTS **** Hyg/Asst: _____

«MedAlerts»

Dentist's Signature _____ *Date* ____/____/____

MEDICAL HISTORY

DENTAL HISTORY

Name _____ **Birthdate** ____/____/_____

What is the reason for initial visit? _____

_____

Do you have a problem? _____

_____

How long since last dental visit? _____ Dental cleaning? _____

How often did you see the dentist/hygienist? _____

How often do you brush? _____ Floss? _____

Do you experience any of the following?

Yes / No - clench or grind your teeth
Yes / No - jaw clicks or pops
Yes / No - pain in muscles of face or around ears
Yes / No - frequent head, neck, or shoulder aches
Yes / No - teeth sensitive to: hot? / cold? / sweet? / pressure?
Yes / No - gums bleed or hurt
Yes / No - dry mouth
Yes / No - bad breath
Yes / No - get food caught in teeth
Yes / No - loose, shifted or chipped teeth
Yes / No - unhappy with appearance of your teeth

Have you had any of the following?

Yes / No - gum treatment or surgery
Yes / No - braces
Yes / No - problems with previous dental treatment
Yes / No - unpleasant dental experiences
If yes, please explain. _____
Yes / No - strong dislike of some aspect of dentistry
If yes, please explain. _____

How do your feel about your teeth in general? _____

_____

Do you have any questions or concerns? _____

_____

By my signature below, I certify that the above information is complete and accurate.

Patient's / Guardian's
Signature X _____ ***Date*** ____/____/_____

FOR OFFICE USE

MEDICAL ALERTS

Dentist's Signature _____ *Date* ____/____/_____

DENTAL HISTORY

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 __/__/__ 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 reserve the right to make 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 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 practices or for additional copies of this notice please contact us using this information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: 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 you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals, evaluating practitioners 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 you health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose you health informati on 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 this 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 healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN 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 you care of you location you 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 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 healthcare. We will also use our professional judgment and our experience with common practices to make reason able inferences of your best interest in allowing a person to pick up filled 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.

REQUIERED 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 are possible 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 you health or safety or the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, (full name) _____, did receive a copy of this office's Notice of Privacy Practices on (today's date) _____.

BELOW LINE FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

_____

_____

_____

This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002). ED 2012