

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
 EMAIL Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

Please list all medications and dosages you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Have you ever had any complications following dental treatment?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
 If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_

### Responsible Party Information

The following is for:  patient  the person responsible for payment Relationship to patient \_\_\_\_\_

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment Relationship to patient \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **ProHealth Dental** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent for Dental Treatment and Acknowledgement of Receipt of Information**

State law requires our office to obtain your consent for your contemplated oral care and dental treatment. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain and discuss your concerns and questions.

I hereby authorize consent for oral and dental treatment that may include, but not limited to, the following: examination, radiographs (x-rays), diagnosis, dental prophylaxis (cleaning), fluoride treatment, restorations (i.e. fillings, pulpotomy, stainless steel crowns), anesthesia, oral surgery (extractions), interceptive orthodontic treatment, and emergency treatment.

I understand that during the course of any planned procedure, unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those originally contemplated. In addition, although I am not advised that positive results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, there can be no guarantee expressed or implied either as to the result of treatment.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. These risks include, but are not limited to the following: nausea following anesthesia, numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of various materials (i.e. stainless steel crowns), injury to the tongue, lips, and cheeks, damage to possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complication may require additional medical, dental, or surgical treatment and may require hospitalization.

### **Understanding this Form**

I hereby state that I have read and understand this consent form, that I have been given the opportunity to ask questions that I might have, and that all questions have been answered in a satisfactory manner. I understand that I have all the right to be provided with answers to questions that may arise during the course of my treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that my consent will remain in effect until such time that I choose to withdraw it.

Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

# Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment may be paid in minimum of two payments or based on the number of appointments to complete treatment.

## Payment options:

1. Cash
2. Check
3. Visa/MasterCard/Discover/AMEX
4. Lending Club

**Patient with insurance:** The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 90 days, we will bill you directly for the full balance.

**Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization). **Parents accompanying their children** are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance.

There is a processing charge for **non-sufficient funds** or returned checks.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **FEE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, \_\_\_\_\_, agree to these financial terms.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Referral Information

Name: \_\_\_\_\_  
*Last* *First*

Date: \_\_\_\_\_

Please tell us how you learned about our practice. (Select ALL that apply.)

\_\_\_\_\_ Friend/Family      Name: \_\_\_\_\_

\_\_\_\_\_ Staff Member      Name: \_\_\_\_\_

\_\_\_\_\_ Other Dentist/Doctor      Name: \_\_\_\_\_

\_\_\_\_\_ Patient of Dr Morgan

\_\_\_\_\_ Our Website

\_\_\_\_\_ Internet Search (e.g. A basic search for "dentist")

\_\_\_\_\_ Insurance Company      Which insurance? \_\_\_\_\_

\_\_\_\_\_ Walked in (saw sign)

\_\_\_\_\_ Radio Ad

\_\_\_\_\_ Ad in Local Publication

\_\_\_\_\_ E-Mail

\_\_\_\_\_ Mailing

\_\_\_\_\_ ProHealth Employee

\_\_\_\_\_ ProHealth Patient

\_\_\_\_\_ ProHealth Pediatric Patient



### Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)*. I understand that this information can and *will* be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by a Legal Representative (Print Name)

\_\_\_\_\_  
Relationship to Patient