Peninsula Family Dental Center

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Patient Information:

Patient Name: _____Preferred Name: _____

Birth Date: _____Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y ☐ N ☐

SS#_____ for insurance purposes, kept confidential Driver's License # _____

Mailing Address: _____City:_____ State:_____ Zip:_____

Physical Address (if different)_____ City: _____ State: _____ Zip: _____

Home Phone #: _____Work #:_____ Cell #: _____

E-Mail address: _____ Best Way to reach you: _____

Employer: _____

Emergency Contact: _____ Phone # _____

Other family members seen by us: _____

How did you hear about us? _____

Parent/Guardian(if patient is a minor) or Person Responsible for Account:

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: _____Birthdate: _____ SS#_____

Insurance Company: _____ Group #: _____

Address: _____ Policyholder's ID #: _____

Patient Relationship to Policyholder: Self_____ Spouse _____ Child _____ Other_____

(Secondary):

Policyholder's Name: _____ Birthdate: _____ SS#_____

Insurance Company: _____Group#: _____ Policyholder's ID #: _____

Address:_____ Employer: _____

Patient Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____

Do you like your smile? Yes ☐ No ☐

What, if anything would you change about your smile? _____

Why have you come to the dentist today? _____

Are you currently in pain? Yes ☐ No ☐ **Do your gums bleed**? Yes ☐ No ☐ **How many times a day do you brush**? _____

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes ☐ No ☐

Have you ever been diagnosed with Gum Disease? Yes ☐ No ☐

Do you need a pre-med before dental appointments? Yes ☐ No ☐ If yes, How long ago? _____

Previous Dentist or Dental Office: _____ Last Visit: _____

Do you smoke or use chewing tobacco? Yes ☐ No ☐ If yes, how long? _____ How often? _____

Physician's Name: _____ Phone # _____

Women: Are you or could you be pregnant? Yes ☐ NO ☐ Are you nursing? Yes ☐ NO ☐

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

☐ Rheumatic Fever	☐ Epilepsy/Seizures	☐ Tuberculosis	☐ Hepatitis
☐ Low Blood Pressure	☐ Heart Murmur	☐ Diabetes	☐ Asthma
☐ HIV/AIDS	☐ High Blood Pressure	☐ Mitral Valve Prolapse	☐ Glaucoma
☐ Sinus Problems	☐ Blood Transfusion	☐ Heart Attack/Stroke	☐ Artificial Valve/Joint
☐ Arthritis	☐ Cancer/Chemo	☐ Drug/Alcohol Abuse	☐ Pacemaker/Heart Surgery
☐ Any implant/transplant	☐ Kidney Problems	☐ Severe Headaches	☐ Psychiatric Care
☐ Excessive bleeding/bruising			

Please list any other medical condition not listed: _____

Are you allergic to any of the following? Please circle either yes or no for each one.

Latex: Y ☐ N ☐	Penicillin: Y ☐ N ☐	Aspirin: Y ☐ N ☐	Erythromycin: Y ☐ N ☐
Codeine: Y ☐ N ☐	Tetracycline: Y ☐ N ☐	Ibuprofen: Y ☐ N ☐	Tylenol: Y ☐ N ☐
Sulfa: Y ☐ N ☐	Dental Anesthetics: Y ☐ N ☐		

Other: _____

Please list ALL medications you are currently taken:

Name:	Dosage:	Times a day

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 is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____ Date: _____

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 the practice, I agree to pay the charges for the services at the time of treatment.

Signature: _____ **Date:** _____

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, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 of copy of our Notice at any time. You may contact us to request more information about our privacy practices.

USES AND DSICLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. We may uses 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: _____ **Date:** _____

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.

Patient/Guardian Signature_____ **Date:** _____

Please list all members of the family

_____