PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name____
Last First MI (Preferred Name)

Birthdate________________ SS#________________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone_____________________ Work Phone____________________ Cell Phone____________________

Email____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] CellPhone [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] CellPhone [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] CellPhone [ ] Email

Student status if dependent over 19 (for insurance purposes) [ ] Non-student [ ] Full-time [ ] Part-time

Where do you go to school? ____

How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

What was the approximate date of your last dental visit? ____

ADDRESS

Check box if same for entire family [ ]

Address____

Address 2____

City_________________________________ State________Zip_____________________

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_______________________________________Subscriber ID # ____________________________

Insurance Company ____Phone_____________________________

Employer____________________________Group Name_______________________Group #__________________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_______________________________________Subscriber ID # ____________________________

Insurance Company ____Phone_____________________________

Employer____________________________Group Name_______________________Group #__________________

Financial Policy

For your convenience we accept Visa, MasterCard, Discover, American Express, check or cash. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered unless other arrangements have been made in advance. If you have questions regarding your account, please contact us. Many times, a simple telephone call will clear any misunderstandings.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and bill them directly for reimbursement of your treatment.

Please remember you are ultimately responsible for all fees charged by this office regardless of your insurance coverage.

Most insurance companies will respond within four to six weeks. However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Depending on your carrier, certain restrictions may apply.

Assignment of Benefits

I authorize the use of this form on all my insurance submissions and I authorize New Leaf Dental to release all information provided by me to all my insurance companies for purposes of insurance claim submissions. I authorize New Leaf Dental to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to New Leaf Dental . I permit a copy of this authorization to be used in place of the original. I give New Leaf Dental, its employees, and/or other agents express prior consent to contact me at any/all phone numbers including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance or payment.

SIGNED:____ Date:____________________

PRINTED NAME:__________________________________

CONSENT TO ELECTRONIC COMMUNICATIONS VIA EMAIL

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk of receiving information via email.
I understand I can withdraw my consent at any time.

☐ I consent only to receiving appointment and recall reminders via email.
I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any information via email.
I understand that I can change my mind and provide consent later.

PATIENT'S PRINTED NAME:____

SIGNED:____ Date:____________________

PRINTED NAME (of parent or guardian, if applicable):

____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us , whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

-- Treatment means providing coordination or managing health care and related services by one or more health care providers. An example of this would include sharing x-rays with a referred specialist or another provider of your choice.
-- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
-- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The following are your rights to your protected health information.
-- The right to request restrictions on certain disclosures of protected health information, including those related to disclosures to family members, relatives, personal friends or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it (except in an emergency).
-- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. (Requests must be in writing).
-- The right to inspect and copy your protected health information. (Request must be in writing).
-- The right to amend your protected health information. (Request must be in writing and explain why the information should be amended).
-- The right to receive an accounting of disclosures of protected health information for the last six years, but not before April 14, 2003.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

(*PATIENT’S COPY TO KEEP*)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third –party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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. I also 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.

PATIENT'S PRINTED NAME:____

SIGNED:_______________________________________ Date:__________________

PRINTED NAME (of parent or guardian, if applicable):

____

DENTAL HISTORY

*Patient Name:*____

Reason for today's visit___________________________
____
____

Former Dentist_______________________________
Reason for leaving ___________________________

Date of last dental visit_______________________
Date of last dental x-rays______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Tobacco products	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Headache/Neck Pain	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Any hospitalizations?	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No

Reason_________________________
____

Interested in Whitening? ☐ Yes ☐ No
How often do you floss?____________________
How often do you brush?____________________

HEALTH HISTORY

Physician's Name____ Date of last visit______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have ever had any of the following:

AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with Extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or Bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems/Surgery	☐ Yes	☐ No
Hepatitis Type________	☐ Yes	☐ No
Herpes/Fever Blisters	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Bone Density Medications	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet/Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or Growth on Head or Neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, Unexplained	☐ Yes	☐ No

Women:

Are you pregnant? ☐ Yes ☐ No   Due Date:_______________________   Are You Nursing? ☐ Yes ☐ No

Taking Birth Control Pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking, Prescription or Non-Prescription
____
____
____

Pre-Med Needed: ☐ Yes ☐ No

ALLERGIES

- ☐ Aspirin
- ☐ Valium
- ☐ Codeine
- ☐ Tetracycline
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Other_______________
____

SIGNED:_______________________________________ ***DATE:***____________________