Smiles to You

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PATIENT INFORMATION

Patient's Name: ________________________________ **Sex:** _______**Today's Date:** ________________________

Patient's Home Address: _______________________**City, State, Zip:** ____________________________________

Social Security #: ____-____-______ **Birthdate:** ________ (*Circle one)* **Married Single Divorced Widowed**

Spouse's Name: __________________________ **Family Contact Name:** ________________ **Phone:** ____________

BILLING, CREDIT AND INSURANCE INFORMATION: **Not covered by dental insurance**

Dental insurance company: ______________________________ **Group number:** _____________________________

Covered by spouse's insurance? *Yes No* **Spouse's dental insurance company:** ______________________

Group number: _________________ **Spouse's birthday:** _________ **Social Security number:** __________________

Senior Living Community: ________________________________ **City, State, Zip:** ___________________________

Phone: _______________________________ **Facility Contact:** ________________________**Title:**_______________

Name of Physician: _______________________ **Physician's Address:** ______________________________________

City, State, Zip: _____________________________________**Physician's Phone:** ____________________________

MEDICAL HEALTH HISTORY

Do you have or have you ever had any of the following?
(Please check any that apply)

Cancer or tumor
Heart ailment or angina
High or low blood pressure
Heart murmur, mitral valve prolapse, heart defect
Rheumatic fever or rheumatic heart disease
Pacemaker
Epilepsy, seizures, or fainting spells
Hip/Joint Replacement
Arthritis
Asthma
Hayfever or sinus trouble
Allergies or hives
Herpes or cold sores
Kidney disease
Hepatitis or other liver disease
AIDS or HIV Positive
Anemia or blood disorder
Stroke
Parkinson's Disease
Dementia or Alzheimer's Disease

Are you allergic to, or have you reacted to any of the following?

Latex materials
Penicillin or other antibiotics
Local anesthetics
Codeine or other narcotics
Sulfa drugs
Barbiturates, sedatives or sleeping pills
Aspirin
Other:________________________________

Are you taking any of the following?
(Please list medication/dosage)

Insulin, Orinase, or other diabetes drug
Aspirin
Anticoagulants (blood thinners)
High blood pressure medicine
Antibiotics or sulfa drugs
Antidepressants or tranquilizers
Nitroglycerin
Cortisone or other steroids
Osteoporosis (bone density) medicine

Do you have any other disease, condition or problem not mentioned above? _____________________________

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PLEASE COMPLETE THE REMAINDER OF THIS FORM- PAGE 2. THANK YOU

PATIENT INFORMATION, MEDICAL HISTORY, CONSENT FOR TREATMENT AND PRIVACY ACT

(Continued)

All Information regarding dental insurance is necessary. We attain this information only to assist those who receive services by obtaining forms at their request. All payments are due at time of service ONLY. If payment arrangements via credit card, debit card or personal check are not made available at time of service, this will cause delay in treatment.

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information that describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/ dental information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

NAME OF RESPONSIBLE PARTY: ____ Phone: ________________
Please Print

Fax: _________________Email:____________________ Mailing Address: ____________________________________

City, State, Zip: ______________________________________ Relationship to Patient: ________________________

Permission Granted for Review of Medical Records.
An associate DDS or RDH may be the provider of mobile dental hygiene services.
Permission Granted to take pictures of patient for chart identification and educational purposes.
Permission Granted to treat patient based on recommendations ordered by staff dentist.
All fees are the responsibility of the "Responsible Party" at time of service.

Signature of Responsible Party:

____ Date: ______________________

(If Applicable)
Signature of Power of Attorney for Health Care

____Date: _____________________

Smiles to You PLLC **Phone: (757) 927-2238 Fax: (757) 223-4809**