Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Guest, Guest & Guest Dentistry

Welcome to Guest Dentistry – Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City _____ State _____ ZIP_____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____ (Please circle preference)

■ Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Guest Dentistry 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: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other

Yes	No	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of Weeks _____
☐	☐	Are you nursing?

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

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

Signature: _____ Date: _____

Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job,moving,relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

Here at Guest Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

☐ Teeth Whitening	☐ Veneers	☐ Invisalign
☐ Traditional Orthodontics (Brackets)	☐ Smile Makeover	☐ Bonding
☐ Sealants	☐ Crown and Bridge	☐ Implant Crowns
☐ Partials/Dentures	☐ Night/Sport Guards	☐ Botox/Xeomin