PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

MEDICAL HISTORY

All information will be held in strict confidence.

Patient's Name _____ Birthdate _____

Primary Care Physician _____ City _____ Physician's Phone (_____)_____

List the **MEDICAL SPECIALISTS** you have seen

Physician's Name	Specialty	Physician's Name	Specialty

DESCRIBE YOUR OVERALL HEALTH: ☐ Outstanding (better than most people my age) ☐ Good (I don't know of any medical problem)
☐ Fair (I have some health problems but they're under control) ☐ Guarded (I have some current health problems) ☐ Poor (I have some major health problems)

WHEN WAS THE LAST TIME YOU SAW YOUR PHYSICIAN? _____(year) What was the purpose? _____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS? ☐ No ☐ Yes, describe _____

HABITS

Cigarettes ☐ Never smoked ☐ Smoked but quit. When? _____ ☐ Currently smoking. Amount? _____ Start date _____
☐ Cigars or ☐ Pipe: ☐ Never smoked ☐ Smoked but quit. When? _____ ☐ Currently smoking. Amount? _____ Start date _____
Smokeless tobacco: ☐ Never smoked ☐ Used, but quit. When? _____ ☐ Currently using. Amount? _____ Start date _____
Have you tried to quit? ☐N/A ☐ No ☐ Yes How many times? _____ What technique did you use? ☐ Abstain ☐ Nicotine patches ☐ Nicotine gum ☐ Hypnosis

Alcohol Consumption: ☐ Total abstinence ☐ Other, describe frequency & amount _____

Do you use any recreational drugs? ☐ No ☐ Yes

WOMEN

Are you pregnant? ☐ No ☐ Yes, estimated due date _____ Are you nursing? ☐ No ☐ Yes
Are you taking oral contraceptives? ☐ No ☐ Yes Are you undergoing hormone replacement therapy? ☐ No ☐ Yes
Are you under treatment for osteoporosis and taking a class of medications call BISPHOSPHONATES? ☐ No ☐ Yes, which one _____
(Some [BUT NOT ALL] common names include Actonel®, Boniva®, Fosamax®, Fosamax Plus D®, Skelid® & Didronel®)

ALLERGIES: Are you allergic to any of the following? ☐ Check here, if no known allergies

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other antibiotics ☐ Codeine ☐ Local anesthetic ☐ Aspirin ☐ NSAIDs like Motrin® ☐ Metals ☐ Other _____
Name the specific medication and describe your reaction:

Do you have or have you had any of the following?

HEART/VASCULAR
- ☐ ☐ Heart attack (MI)
- ☐ ☐ Congenital heart defect
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Irregular heartbeat (missed beats)
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Angina / Chest pains
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Artificial heart valve(s)
- ☐ ☐ Pacemaker
- ☐ ☐ By-pass surgery
- ☐ ☐ Stent placement
- ☐ ☐ Congestive heart failure
- ☐ ☐ Swelling of ankles
- ☐ ☐ Shortness of breath
- ☐ ☐ Other heart disease

BLOOD
- ☐ ☐ Anemia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Hemophilia
- ☐ ☐ Bruise very easily
- ☐ ☐ Prolonged bleeding
- ☐ ☐ HIV / AIDS

RESPIRATORY
- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Persistent cough
- ☐ ☐ Coughing up blood/sputum
- ☐ ☐ Difficulty breathing while lying down
- ☐ ☐ Winded going up 1 flight of stairs
- ☐ ☐ Lung cancer
- ☐ ☐ Other lung disease

BONE
- ☐ ☐ Arthritis / Rheumatism
- ☐ ☐ Osteoporosis
- ☐ ☐ Gout
- ☐ ☐ Artificial joints or limbs

URINARY
- ☐ ☐ Kidney disease
- ☐ ☐ Renal dialysis
- ☐ ☐ Very frequent urination
- ☐ ☐ Burning on urination
- ☐ ☐ Blood or discharge in urine
- ☐ ☐ Venereal disease
- ☐ ☐ Genital herpes

NERVOUS SYSTEM
- ☐ ☐ Stroke (CVA) or TIA
- ☐ ☐ Severe headaches / Migraines
- ☐ ☐ Fainting or dizzy spells
- ☐ ☐ Convulsions or epilepsy
- ☐ ☐ Numbness or tingling

ENDOCRINE
- ☐ ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ ☐ Excessive thirst
- ☐ ☐ Thyroid disease
- ☐ ☐ Hypoglycemia

MENTAL HEALTH
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Panic attacks
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Bipolar (manic – depressive)
- ☐ ☐ Addiction disorders _____
- ☐ ☐ Other _____

HEAD/NECK/EYES
- ☐ ☐ Glaucoma
- ☐ ☐ Macular Degeneration
- ☐ ☐ Loss of hearing
- ☐ ☐ Tonsillitis
- ☐ ☐ Sinus problems

DIGESTIVE SYSTEM
- ☐ ☐ Hepatitis, Type ____
- ☐ ☐ Gastric reflux
- ☐ ☐ Ulcers
- ☐ ☐ Frequent diarrhea
- ☐ ☐ Crohn's dis. or colitis

CANCER
- ☐ ☐ Tumor _____
- ☐ ☐ Radiation treatment
- ☐ ☐ Chemotherapy
- ☐ ☐ Organ removal

☐ ☐ **ORGAN TRANSPLANT**

TO THE BEST OF MY KNOWLEDGE, ALL THE ABOVE INFORMATION IS CORRECT.

Signed _____ Date _____

DOCTOR'S NOTES

Patient's Name _____

List any surgeries or major health events	
Year	Event

Medications INCLUDING over-the-counter medications and herbal supplements		
Name of medicine	Dosage	Purpose: Why are you taking it?

MEDICAL HISTORY UPDATES

1 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

2 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

3 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

4 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

5 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

6 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

Live Oak Family Dentistry

Office Policies

Dental treatment is an excellent investment in an individual's overall health and well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact people have different needs in fulfilling their financial obligation, we provide the following payment options.

Payment Policy:

Cash, Check, Visa, Mastercard, American Express, Discover, and Care Credit.

Insurance Policy:

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, **we can make no guarantee of any estimated coverage.** Because your insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not pay their estimated benefits, you are then responsible for the balance.

Please be advised, Live Oak Family Dentistry is NOT an in-network provider (NOT UNDER CONTRACT) with any insurance company. _____initial

Cancellation/No Show Policy:

Our goal is to provide you with quality dental care and personal attention. Your appointment time is reserved just for you. **If you need to cancel your appointment, please notify us at least 24 hours in advance.** Cancellations made less than 24 hours in advance will be considered the same as a no-show and a $50.00 broken appointment fee may be assessed to your account. _____ initial

Family/ Multiple Same Day Appointment Policy:

We strive to accommodate families desiring multiple same day appointments as best we can. These significant blocks of time are reserved especially for your convenience and they are not always readily available. **If you need to cancel, we request that you notify us 48 hours in advance.** Failure to do so may result in a $50.00 broken appointment fee being charged to your account per appointment. _____initial

Acknowledgement:

I hereby acknowledge and agree to the above office policies.

_____	_____	_____
Date	Print Patient Name	Patient Signature

LIVE OAK FAMILY DENTISTRY

PATIENT CONSENT FORM (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

2. Obtaining payment from third party payers (e.g. my insurance company)

3. The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:_____Date:_____

Relationship to Patient:_____

Signature:_____

LIVE OAK FAMILY DENTISTRY
HIPAA RELEASE FORM

I,_____, authorize the release of information of
(PRINT PATIENT/GUARDIAN NAME)

_____, including the diagnosis, records,
(PATIENT NAME)

examination and treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (Check one):
( ) Spouse_____
( ) Child(ren)_____
( ) Other_____
( ) Information is not to be released to anyone. (Initial Here_____

In further consideration for this, Live Oak Family Dentistry agrees to the same stipulations. This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date_____/____/_____
Witness: _____ Date_____/____/_____