



Date: _____

Chart : _____

Patient Name: _____ Middle Initial: _____ DOB: _____ Sex: Male / Female
Address: _____ City: _____ State: _____ Zip Code: _____
Cell Phone #: _____ Work #: _____ EXT _____ Home Phone #: _____
Patient Social Security#: _____ Drivers Lic/ID #: _____ Preferred Name: _____
Email: _____ Marital Status: married/divorced/single/widowed

Responsible Party Name: _____ DOB: _____ Sex: Male / Female
Address: _____ City: _____ State: _____ Zip Code: _____
Cell Phone #: _____ Work #: _____ EXT _____ Home Phone #: _____
Social Security#: _____ Drivers Lic/ID #: _____ Policy Holder: Y / N

Please circle how you heard about us? Insurance Mailer Patient Google Facebook Other _____
Previous Dentist: _____ Date of last dental visit: _____/Cleaning: _____
Reason for your visit?: _____

Primary Insurance Name: _____ ID #: _____
Insurance Phone #: _____ Name of Employer: _____
Insurance Co Address: _____ City: _____ State: _____ Zip Code: _____
Name of Insured/Policy Holder/Subscriber: _____ DOB: _____
Social Security#: _____ Relationship to patient: _____

Secondary Insurance Name: _____ ID #: _____
Insurance Phone #: _____ Name of Employer: _____
Insurance Co Address: _____ City: _____ State: _____ Zip Code: _____
Name of Insured/Policy Holder/Subscriber: _____ DOB: _____
Social Security#: _____ Relationship to patient: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Do you need to pre-medicate? Yes No If yes, please explain: _____
- Do you take Fosamax? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Latex Penicillin Codeine Aspirin Local Anesthetics Metal Acrylic

Other If yes, please explain: _____

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

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Are you taking any medications:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SIGNATURE OF DOCTOR _____ DATE _____

General Treatment Consent Form

Patient Name : _____

Chart : _____

1. CONSENT FOR TREATMENT

I give permission to Sol Dental and the office staff to treat any of my oral and dental related problems. These include but are not limited to oral exam, professional cleaning, filling, extraction, etc. I understand that during the treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy following routine filling procedures. I give permissions to the dentist to make any addition necessary changes. (initials)_____

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working other teeth that were not discovered during examination,the most common being root canaltherapy following routine restorative procedure. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials)_____

3. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues,pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) (initials)_____

4. NITROUS OXIDE

I understand that the administration of nitrous oxide (laughing gas) carry certain common hazards; risks and potential unpleasant side effects which are infrequent, but nonetheless occur. These Include, but are not limited to sweating,nausea,and vomiting. Please let the Dentist know if you experience these symptoms as the levelof nitrous oxide can be adjusted. Recovery time is usually short, but may be prolonged, requiring you to remain in the office for some time. Although not usually required, it may be best to have a responsible adult accompany you to drive you home. You may have a light meal a few hours before the procedure. If you are pregnant or think you are pregnant please let the Dentist know as Nitrous Oxide can cause premature birth.(initials) _____

5. CROWNS ,BRIDGESAND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown, bridge, or cap(including shape, fit,size, and color) will be before cementation.(initials)_____

6. DENTURES COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and /or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that some dentures require relining approximately after initial placement. The cost for this procedure is not included in the initial denture fee. (initials) _____

7. PERIODONTAL LOSS (TISSUE & BONE)

I understand that if nothing is done to correct my dental condition any of the following may occur: limited function gum or bone disease, loss of supporting bone, inflammation, infection, looseness of teeth, shifting of teeth, and the possible deterioration such that treatment will not be possible in the future. I further understand that periodontal disease is chronic and progressive and following correction through treatment may recur and cause further loss of supporting bone, periodontal pocketing, and bone loss. Additional periodontal treatment may become necessary and be suggested in the future and/or tooth loss. (initials) _____

8. Fillings:

I understand that care must be exercised in chewing on fillings. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that sensitivity is common after effect of a newly placed filling or large filling. (initials) _____

I understand that dentistry is not an exact science and that, therefore, reputable, practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment. (initials) _____

I, Dr. _____ have verbally explained the risks and complications of this treatment to the patient as well as presenting the alternative treatment plan.

Signature of Patient/Guardian _____ Date _____

Signature of Dentist _____ Date _____

Signature of Witness _____ Date _____

Financial agreement and insurance benefits assignment

Patient Name: _____

Date: _____

I authorize my insurance carrier to issue the dental benefits of my plan directly to the dental office. I also authorize release of information necessary to process dental insurance. **I understand that regardless of insurance, I am responsible for the total amount for the treatment done.**

I understand that, signing this form does not imply in any way that my insurance company will cover any of the services rendered by *Sol Dental's* staff. Our office or its employees cannot guarantee the accuracy of any information given by my insurance company regarding my benefits. Based on such information given by my insurance company, *Sol Dental's* staff will compute an estimate of payment due, as described in the "treatment plan" document. Payment is due on the day the services are rendered (referred to as Service Date from here onwards).

I understand that our office's staff may file for payments with my insurance company. If my insurance company does not pay *Sol Dental* for all the services rendered, in full, within 90 days from the Service Date, I am responsible for the remainder of the amount due immediately.

I understand that any amount that is not paid within 90 days from the Service Date is considered "Past Due". A finance charge of 1.5% per month will be applied on all of the "Past Due" amounts from the Service Date onwards until all such "Past Due" amounts are paid in full.

I understand that there is a "**returned check fee**" on any checks written to the extent allowed by law plus a check handling fee of **\$35** per returned check incidence. Solely at the discretion of our office, the check may be turned over to the District Attorney's office for legal action. If the account is "Past Due" finance charges of 1.5% per month will be applied on such fees as well.

I understand that after reasonable attempts at collecting payments for services rendered and any finance charges and other charges to the account, *Sol Dental* may send the account for collection to a collection agency or small claims court, solely at the discretion of the office. If the collection agency or small claims court is unable to collect full payment within a reasonable duration, the account may be reported as delinquent to Credit Reporting Agencies. All rights reserved by *Sol Dental*.

Patient/Parent/Guardian signature

Date:

Witness _____

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some change in our office management procedures to make sure we follow the health information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these new rights. We are happy to answer any question you may have.

Control Over Your Health Information

All health care providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver. We must by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine users and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why. Authorizations of non-routine information are one-time –only, case by case, for the use defined by you.

Access to Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get your a copy of your records within 60 days of your request. There may be a cost for this service. Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed. You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse if Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights. 200 Independence Avenue, SW, Washington, D.C. 20201. If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way. Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries: Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions, or to financial institutions – without your explicit authorization. There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment. Use only the minimum amount of information necessary. In General, use or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Out compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Patient/Guardian Signature

Print Name

Date