Patient Information

Patient Name _____

Family Status: Married ____ Single____ Child_____ Other_____ Social Security___-___-_____

Birth Date: __/___/____ Email Address: _____

Phone: Cell ( )____-_____ Work ( )_____-_____ Home ( )_____-_____

Address: _____ City _____ Zip _____

Whom may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for: ___the patient's spouse ___the person responsible for payment ___NA

Patient Name _____

Family Status: Married ____ Single____ Child_____ Other_____ Social Security___-___-_____

Birth Date: __/___/____ Email Address: _____

Phone: Cell ( )____-_____ Work ( )_____-_____ Home ( )_____-_____

Address: _____ City _____ Zip _____

Employment Information

The following is for: ___the patient's spouse ___the person responsible for payment

Employer Name: _____ Phone: ( )_____-_____

Address: _____ City _____ Zip _____

Primary Insurance Information

Primary Dental Insurance:_____ Group #:_____ ID#:_____

Insurance Address:_____City: _____Zip:_____

Name of Insured: _____ Insured Birth Date: ___/____/_____

Insured's Address: _____ City: _____ Zip: _____

Employer Address:_____City: _____Zip:_____

Patient's relationship to insured: Self_____ Spouse_____ Child _____

Secondary Insurance Information

Primary Dental Insurance:_____ Group #:_____ ID#:_____

Insurance Address:_____City: _____Zip:_____

Name of Insured: _____ Insured Birth Date: ___/____/_____

Insured's Address: _____ City: _____ Zip: _____

Employer Address:_____City: _____Zip:_____

Patient's relationship to insured: Self_____ Spouse_____ Child _____

Dental Health History

Patient Name: _____

Reason for today's visit: _____

Date of last dental care: ___/___/____ Date of last dental x-rays:___/___/_____

Former dentist:_____ Physician's Name:_____

How often do you brush? _____ Floss?_____

Does your drinking water contain fluoride? Yes____ No_____

Are you happy with the appearance of your teeth? Yes ____ No_____ Reason:_____

Do you have any of the following?

___Bad Breath ____Bleeding gums

___Clicking or popping jaw ____Food collection between teeth

___Frequent headaches ____Grinding teeth

___Loose teeth or broken fillings ____Periodontal treatment

___Sensitivity to cold ____Sensitivity to hot

___Sensitivity to sweets ____ Sensitivity to biting

___Sores or growths in your mouth ____Dry mouth

Have you ever taken bisphosphonates or any medication to control bone loss?_____

__Pre-Med Amox	__Pre-Med Clinda	__Pre-Med other	__Allergies
__Allergy Aspirin	__Allergy codeine	__Allergy – Erythro	__Allergy – Hay Fever
__Allergy – Latex	__Allergy – other	__Allergy – Penicillin	__Allergy – Sufla
__Alzheimer's	__Anaphylaxis	__Anemia	__Angina
__Arthritis	__Artificial Joints		__Asthma
__Blood disease	__Cancer	__Chemotherapy	__Chest pains
__Congenital Problems	__Cortisone treatment	__Diabetes	__Dizziness
__Epilepsy	__Excessive Bleeding	__Fainting	__Glaucoma
__Head injuries	__Heart Disease	__Heart murmur	__Hemophilia
__Hepatitis	__Herpes	__High blood pressure	__HIV
__Hypoglycemia	__Jaundice	__Kidney Disease	__Liver Disease
__Mental Disorders	__Mitral Valve Prolapse	__Nervous Disorders	__Osteoporosis
__Other	__Pacemaker	__Pregnancy	__Radiation Treatment
__Respiratory Problem	__Rheumatic Fever	__Rheumatism	__Scarlet Fever
__Sinus Problems	__Stomach problems	__Stroke	__Swelling of feet
__Tuberculosis	__Tumors	__Ulcers	__Venereal Disease

List medications currently taking: _____

_____

Pharmacy name and phone number: _____

Tobacco habits/controlled substances/recreational drugs? Please list_____

Other:_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

I understand and acknowledge that I am ultimately financially responsible for the services provided for myself or the above named, regardless of insurance coverage. I also understand that I or the above named is responsible for knowing their insurance coverage. A 5% monthly fee will be charged on account balances over 30 days. No shows or being more than 10 minutes late for your scheduled appointment will be subject to a broken appointment fee of $50.00. If you need to cancel your appointment a 48-hour cancellation notice is required to not be charged a $50 fee. This fee is not covered by any insurance and will be the patient's responsibility. Please sign and date.

Signature:_____ Date ___/___/_____

pike DENTISTRY
COURTNEY J PIKE DDS

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

Print name: _____

Signature: _____

Relationship to Patient (if other than patient):_____

Date:_____

Witness:
Practice Representative Signature:_____