Complete Care Dental

Patient Dental Intake Form

Patient Information

Name:_____Birthdate:_____
Address: _____City:_____ State:_____ Zip:_____
Home phone:_____ Cell phone:_____ Email: _____
Sex: ( )M ( )F Marital status: ( )Minor ( )Single ( )Married ( )Widowed
Employer or School:_____
Spouse, partner or parent name: _____
Emergency Contact Name:_____ Phone:_____
Are any of your family members our patients? (Yes/No)
If Yes, who? _____ Relation to you:_____
How did you learn about our practice or whom may we thank for referring you?_____

Dental Insurance

Insurance company:_____ Phone:_____
Subscriber's Social Security #:_____ Group #:_____ ID #: _____
Who's the policy holder? _____ Policy holder Date of Birth: _____
Employer offering this insurance?_____ Phone:_____
Do you have any additional insurance? (*if applicable, please complete the following)*
Insurance company:_____ Phone:_____
Subscriber's Social Security #:_____ Group #:_____ ID #: _____
Who's the policy holder? _____ Policy holder Date of Birth: _____
Employer offering this insurance?_____ Phone:_____

Dental History

Reason for today's visit:_____
Date of last dental care visit:_____
Check if you have any problem with the following:

- ❑ Bad breath
- ❑ Grinding teeth
- ❑ Food collection between certain teeth
- ❑ Sensitivity to any of the following: cold, hot, sweets
- ❑ Sores or growth in your mouth
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between certain teeth
- ❑ Periodontal treatment
- ❑ Sensitivity when biting

How often do you floss? _____How often do you brush? _____
Tell us a little about your teeth? _____
Do you like your smile? _____

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Medical History Form

Your physician: _____ Date of last visit: _____
Have you ever taken Fen-Phen/Redux? ( ) Yes ( ) No
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ( ) Yes ( ) No
Have you ever had Endocarditis? ( ) Yes ( ) No If Yes, when?:_____
Have you had any serious illnesses or operations? ( ) Yes ( ) No If yes, describe: _____
Have you ever had a blood transfusion? ( )Yes ( )No If yes, give approximate dates:_____
Have you ever had any radiation to the head and neck? ( ) Yes ( ) No If Yes, When:_____
Have you ever had a joint replacement? ( ) Yes ( )No If yes, what joint and when: _____
Women: Are you pregnant? ( ) Yes ( ) No
Are you nursing? ( )Yes ( )No Are you taking birth control? ( )Yes ( )No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV or AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid Problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications (including non-prescription) you are currently taking and the correlating diagnosis:

Are you Allergic or have you reacted adversely to any of the following?

❑Latex	❑Ibuprofen	❑Penicillin	❑Latex	❑Codeine
❑Penicillin	❑Aspirin	❑Sulfa	❑Local Anesthetic	❑Erythromycin

Other: _____

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health

Name: _____ Date: _____
Patient or Guardian Signature: _____

Complete Care Dental

Consent for Treatment

1. I hereby authorize and direct the dentist(s) of Complete Care Dental to perform the following dental treatment or oral surgery procedure(s), if needed, including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids:
-Preventative hygiene treatment (prophylaxis), comprehensive exam and application of fluoride
- Application of plastic “sealants” to the grooves of the teeth
- Treatment of diseased or injured teeth with endodontic (root canal) therapy if needed. (Detailed consent is provided before said procedure)
- Replacement of missing teeth with dental prosthesis (ie. Implants, bridges, partials, and full dentures).
- Removal (extraction) of one or more teeth. (Detailed consent is provided before said procedure)
- Treatment of diseased or injured oral tissue (hard and/or soft)
-Treatment of malposed (crooked) teeth.
2. I understand that there are risks involved in this treatment, and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well being, in the professional judgment of the dentist.
5. I agree to the use of local anesthesia and understand that there are possible risks and complications associated with the administration of local anesthesia, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctor to use anonymized photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications.
7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.

_____ _____

Print Patient’s Name Print Name of Parent or Guardian (if applicable)

_____ _____

Signature of Patient or Parent/Guardian Date Witness Signature Date

Notice of Privacy Policy

Complete Care Dental

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY AND SIGN ON THE LAST PAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:
Treatment Services: We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
Payment and Health Care Operations: We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
Marketing/Fundraising: We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
Legal Requirements: We may use or disclose your health information when required to do so by law.
Abuse or Neglect: If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
National Security: When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activites. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
Family Members, Friends, and Others Involved in Care: At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

Notice of Privacy Policy (cont'd)

Business Associates: Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Research: We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.

Public Health Activities: We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).

Other Authorizations: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Breach Notification: We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.
We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment.) We may deny your request under certain circumstances.

Complete Care Dental

Patient Full Name: _____ Date: _____

Financial Policy

It is our policy for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all of our patients. Please read the terms of our financial policy below.

-Payment is due at the time of service unless prior arrangements have been made. Any payment owed will be collected prior to being seen by your provider

- We accept most dental insurances:
    - Please note that having active insurance coverage does not mean a guarantee of payment in full. Payment will be determined at the time the claim is processed by your insurance carrier.
    -Treatment plans are an ESTIMATE ONLY, based on information given to us by you and your insurance company.
    - In the event that your insurance company pays less than the estimated amount, you are responsible for the unpaid balance. All treatment cost remains your responsibility, regardless of insurance coverage.
- A fee of $50.00 is charged for patients who miss or cancel more than 3 times in a calendar year without a 48 hour notice.
- We accept the following forms of payment: Cash, Credit Cards, Debit Cards and CareCredit payment programs providing a full range of No Interest and Extended payment plans for all patients and treatments.
    - For checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers processing fees that are charged to our office.
- If you do not have insurance, Complete Care Dental also offers the in house Dental Discount Plan (DDP) designed for your specific needs. Be sure to ask a team member how you and your family can benefit from this program.

I have read and understand and agree to the above Financial Policy

Signature: _____ Date: _____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____