PATIENT INTAKE FORM

Date: _____

Last Name:	First Name:	MI:

1. Patient Information

Sex: ☐ Male ☐ Female Soc. Sec. # _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone # _____

If under 18, Name of Parent: _____ Parent Soc. Sec. # _____

Parent Employer: _____ Parent Phone: _____

Reason for today's visit? _____

How did you hear about us? ☐ Internet/Online ☐ Drive By/Walk-In ☐ Family/Friend ☐ Insurance ☐ School Event ☐ Social Media ☐ Mailer

2. Dental Insurance Information (Primary Carrier)

Policy Holder's Name: _____

Policy Holder's Employer: _____

Policy Holder's DOB: _____

Insurance ID # _____

Insurance Phone # _____

Group # _____ Local # _____

3. Dental Insurance Information (Secondary Carrier)

Do you have secondary insurance? ☐ Yes ☐ No

Policy Holder's Name: _____

Policy Holder's Employer: _____

Policy Holder's DOB: _____

Insurance ID # _____

Insurance Phone # _____

Group # _____ Local # _____

4.Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

☐ **Please check if you would like more information about financing options.**

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

HIPAA and Financial Consent

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

_____ _____

Patient Signature/Legal Guardian **Date**

PATIENT INTAKE FORM

salud DENTAL

Date: _____

Last Name:	First Name:	MI:

5. Dental History Please mark (✓) on any of the following conditions that apply to you

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety 1 2 3 4 5 6 7 8 9 10 ____ Happy with your smile 1 2 3 4 5 6 7 8 9 10 ____

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover

☐ Missing Teeth ☐ Whiter Teeth ☐ Teeth Sensitive to hot, cold, sweets or pressure ☐ Other

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: _____

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath
- ☐ Loose, tipped or shifting teeth
- ☐ Previous perio/gum disease

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Social

Tobacco packs per day: _____

Alcohol frequency: _____

Drugs frequency: _____

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit: _____ Your last cleaning: _____

What is the most important thing to you about your dental visit today? _____

6. Medical History Please mark (✓) as your response to indicate if you have or have had any of the following

Please check if you have any of these conditions: ☐ Artificial Heart Valve ☐ Previous Infective Endocarditis ☐ Unrepaired Cyanotic CHD ☐ Damaged Heart Valves in Heart Transplant ☐ Repaired CHD with Residual Defects

Are you on blood thinners? If yes, please list: _____

Please list medications currently taking: _____

Have you ever in the past, or are you now currently taking, any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications: _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain: _____

Pain/Discomfort
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs

Other allergies/comments

_____

_____

_____

_____

_____

Cancer

Type: _____
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant

Due date: _____
- ☐ Nursing

Are you under the care of a physician? If yes, please explain: _____

Physician Full Name: _____ Phone: _____

Consent:

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient/Legal Guardian	Print Name	Date	Dentist/Hygienist Signature

NOTICE OF PRIVACY PRACTICE

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. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 01/01/2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain. Including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:
Treatment: We may use or disclose your health information to a physician or healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: 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 an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, digital photographs, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Last Name:	First Name:	MI:

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly,
- Obtain payment from third-party payers for my health care services (insurance companies, collection service agencies, etc.)
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date of Birth: _____

I authorize the release of information such as, but not limited to: diagnosis, treatment plan, billing/statement information, insurance and claim information to:

☐ Spouse: _____ ☐ Child (ren): _____

☐ Parents: _____ ☐ Other: _____

Patient or Guardian signature **Date**

Cosmetic Dentistry- Model Release

I, (PLEASE PRINT) _____ (☐ give/ ☐ do not give) Salud Dental permission to record the image and/or voice (testimonial) of the patient named below and I grant Salud Dental all rights to use these sounds, still or moving images in any medium for educational, promotional, advertising or other purposes that support the mission of the dental practice. I agree that all rights to the sound, still or moving images belong to Salud Dental.

Patient's Name (Print): _____

Guardian's name (print-only needed if minor is under 18): _____

Patient or Guardian signature **Date**

Last Name:	First Name:	MI:

Informed Consent to Treatment

Drugs and Medication

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

(Initial: _____)

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed.

(Initial: _____)

X-Rays

I understand x-rays are necessary for proper diagnosis and treatment.

(Initial: _____)

Fillings

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage.

I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling.

(Initial: _____)

Local Anesthetic

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment.

(Initial: _____)

I understand that dentistry is not an exact science, and 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, and my questions have been answered to my satisfaction. I consent to the proposed treatment.

(Initial: _____)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. In general terms, the dental procedure(s) can include is not limited to:
   a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride
   b. Application of resin "sealants" to the grooves of the teeth
   c. Treatment of diseased or injured teeth with dental restorations (fillings)
   d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections
4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
7. **I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.**

Patient Name (Print)

Patient or Parent | Guardian Signature

Date