Patient Information

Patient Name: _____ Date_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home):_____ (Work): _____ Ext: _____ (Cell): _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☒S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
- _____
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Disease
- ☐ Blood thinners
- ☐ Cancer
- ☐ COPD
- ☐ Deep Veins Thrombosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pregnancy
- ☐ Due date :_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stents/heart
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER:_____
- ☐ _____

Have you ever had any complications following dental treatment? ___Yes ___No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ___Yes ___No
If yes, please explain: _____

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

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ___Yes ___No
If yes, please explain: _____

Are you using or taking any other medications, pills, or drugs? ___Yes ___No
If Yes, please specify:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____Date_____

Dentist signature

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Newspaper ☐ School ☐ Work ☐ Other. Name of person referring to our office _____

Spouse or Responsible Party Information

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

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Consent for Internet Communications

I grant my permission to DIMEO FAMILY DENTAL to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for DIMEO FAMILY DENTAL. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand DIMEO FAMILY DENTAL and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that DIMEO FAMILY DENTAL is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand DIMEO FAMILY DENTAL is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the DIMEO FAMILY DENTAL web site with my ID and password. I also agree to immediately notify DIMEO FAMILY DENTAL of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand DIMEO FAMILY DENTAL will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that DIMEO FAMILY DENTAL has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand DIMEO FAMILY DENTAL will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand DIMEO FAMILY DENTAL CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for DIMEO FAMILY DENTAL, and grant DIMEO FAMILY DENTAL permission to securely upload my patient information to the web site.

PATIENT SIGN: _____ Date: _____ Relationship to Patient:_____

EMAIL ADDRESS: _____ (appointment reminders)

Consent for Use and Disclosure of Health Information and Acknowledgement of Receipt of Privacy Requests

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options. This is not a consent to treatment.

Notice of Privacy Practices: You have the right to review and secure a copy of our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notices provides a description of our treatment, payment activities, and healthcare options, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices, which may apply to any of your protected health information that we maintain, as described in our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Patient Signature_____

We may release records to _____

Date_____