brookings dental clinic

Quality Care

PATIENT INFORMATION

Full Name: _____ Pref Name: _____

Guardian Name: _____

Date of Birth: _____ Social Security: _____

Address: _____

City: _____ Phone Number: _____

State/Zip Code: _____ Email Address: _____

Referred By: _____ Married: ☐ Single: ☐ Gender:_____

PERSON RESPONSIBLE FOR ACCOUNT

Patient ☐ Spouse ☐ Guardian ☐ Parent ☐

Parent/Guardian Name:_____ Phone Number_____ SS:_____

Billing Address (if different from mailing): _____

EMERGENCY CONTACT:

_____ Name

_____ Phone Number

INSURANCE INFORMATION

Policy Holder: _____ Date of Birth: _____

Dental Ins. Company: _____ Insurance ID: _____

Employer: _____ Group Number: _____

AUTHORIZATION

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and preform such diagnostic and therapeutic procedures as my be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals. I understand that where appropriate credit bureau reports may be obtained.

If I do not pay the entire balance within 25 Days of the monthly billing date, a SERVICE CHARGE will be added to my account for the current monthly billing period. the service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last months balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and responsible attorney fees incurred to effect collection of this account or future outstanding accounts.

By signing below, I confirm that the above information is filled out to the best of my knowledge. I have read and acknowledged the Authorization above.

_____ _____

Client's Signature: Date:

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Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

Patient Name:

_____

We are required by federal law (HIPAA – Health Insurance Portability and Accountability Act) to provide you with a copy of our Notice of Privacy Practices. This notice describes how your health information may be used and disclosed, and how you can access your information. Please sign below to acknowledge that you have received a copy of our Notice of Privacy Practices.

Acknowledgment

I hereby acknowledge that I have received, read, or had the opportunity to review the Notice of Privacy Practices for Brookings Dental Clinic.

Signature of Patient or Legal Representative:

_____

Date: _____

Relationship to Patient (if signed by legal representative):

_____

Please list anyone that can have access to your dental records

_____

_____

_____

_____

For Office Use Only

If the patient or legal representative did not sign this acknowledgment, please explain why:

□ Patient declined to sign

□ Communication barriers prohibited obtaining acknowledgment

□ Emergency situation prevented obtaining acknowledgment

□ Other (please specify): _____

Staff Member Signature: _____

Date: _____

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Health History Form

Name:_____ DOB:_____

Do you have dental exams on a routine basis? Yes ☐ No ☐

Who is your medical Physician?_____

Indicate which of the following applies to you

- ☐ There have been changes in my general health in the last year
- ☐ I have been hospitalized in the past 3 years
- ☐ I am currently under the care of a physician

Please Explain:_____

_____

_____

Do you have a history of alcohol dependency? Yes ☐ No ☐

Do you use any tobacco or nicotine products? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Do you take antibiotic premedication for your dental visits? Yes ☐ No ☐

Please list any allergies:_____

_____

_____

_____

Please list any medications:_____

_____

_____

_____

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Please indicate any of the following conditions that you currently have or have had:

_____Rheumatic Fever

_____Colitis

_____Chemo or radiation therapy

_____Venereal Disease

_____Swelling of feet/ankles

_____Glaucoma

_____Kidney or bladder trouble

_____Aids (HIV virus)

_____Osteoporosis

_____Drug reactions

_____Arthritis

_____Sinus trouble

_____Stomach problems

_____Ulcers

_____Phycological or emotional problems

_____Chest Pains

_____Liver problems or hepatitis

_____Cancer

_____Severe headaches

_____Shortness of breath

_____Hay fever

_____Convulsions or seizures

_____Diabetes

_____High Blood Pressure

_____Asthma

_____Endocrine disturbances

_____Heart problems

_____Bleeding Problems

_____Joint Replacement

_____Tuberculosis

If "YES" to the above questions, please describe below:_____

_____

_____

_____

_____

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire, and it is accurate to the best of my knowledge. There are no other medical conditions or medications/allergies that have not been listed. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the practice. This will serve as my electronic signature.

YES_____ NO_____