Patient Information

○ Dr. ○ Mr. ○ Mrs. ○ Ms. First Name ______ Last Name _____________ Middle Initial__

Preferred Name ____ Date_________

Whom may we thank for referring you to our office? _________________________________

Patient Information

Address ___________________________ Address 2 _________________________________

City, State, Zip ____

Home Phone ____________ Work Phone ___________ Ext ___ Cell _______________

Sex ○ Male ○ Female

Marital Status ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date ____________________ Age_____ Social Security Number ____________

E-Mail ____

I would like to receive correspondences via e-mail ○ Yes ○ No

Responsible Party (if someone other than the patient)

First Name _____________________ Last Name _________________ Middle Initial __

Address ___________________________ Address 2 _________________________________

City, State, Zip ____

Home Phone ____________ Work Phone ___________ Ext ___ Cell _______________

Birth Date _________________________ Social Security Number ___________________

○ Responsible Party is also a Policy Holder for Patient

○ Primary Insurance Policy Holder

○ Secondary Insurance Policy Holder

Primary Dental Insurance Information

Name of Insured ____

ID # ____________________________________ Group # _____________________________

Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Social Security Number ________ Insured Birth Date ___________________

Employer _____________________________

Address ______________________________

Address 2 ____________________________

City, State, Zip _______________________

Insurance Company ______________

Address ___________________________

Address 2 __________________________

City, State, Zip _____________________

Secondary Dental Insurance Information

Name of Insured ____

ID # ____________________________________ Group # _____________________________

Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Social Security Number ________ Insured Birth Date ___________________

Employer _____________________________

Address ______________________________

Address 2 ____________________________

City, State, Zip ________________________

Insurance Company ______________

Address __________________________

Address 2 _________________________

City, State, Zip _____________________

Medical History Part 1

Patient's Name ____________________________ Birth Date _________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No
If yes, please explain____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No
If yes, please explain____
Have you ever had a serious head or neck injury? ○ Yes ○ No
If yes, please explain____
Are you taking any medications, pills, or drugs? ○ Yes ○ No
If yes, please explain____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No
If yes, please explain____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No
Taking oral contraceptives? ○ Yes ○ No
Nursing? ○ Yes ○ No

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Local Anesthetics ○ Acrylic ○ Metal
○ Latex ○ Sulfa Drugs ○ Other If yes, please explain______________________
____

Medical History Part 2

Do you have, or have you had any of the following?

Condition	Response	Condition	Response
AIDS/HIV Positive	O Yes O No	Heart Attack/Failure	O Yes O No
Alzheimer's Disease	O Yes O No	Heart Murmur	O Yes O No
Anaphylaxis	O Yes O No	Heart Pacemaker	O Yes O No
Anemia	O Yes O No	Heart Trouble/Disease	O Yes O No
Angina	O Yes O No	Hemophilia	O Yes O No
Arthritis/Gout	O Yes O No	Hepatitis A	O Yes O No
Artificial Heart Valve	O Yes O No	Hepatitis B or C	O Yes O No
Artificial Joint	O Yes O No	Herpes	O Yes O No
Asthma	O Yes O No	High Blood Pressure	O Yes O No
Blood Disease	O Yes O No	High Cholesterol	O Yes O No
Blood Transfusion	O Yes O No	Hives or Rash	O Yes O No
Breathing Problem	O Yes O No	Hypoglycemia	O Yes O No
Bruise Easily	O Yes O No	Irregular Heartbeat	O Yes O No
Cancer	O Yes O No	Kidney Problems	O Yes O No
Chemotherapy	O Yes O No	Leukemia	O Yes O No
Chest Pains	O Yes O No	Liver Disease	O Yes O No
Cold Sores	O Yes O No	Low Blood Pressure	O Yes O No
Congenital Heart Disorder	O Yes O No	Lung Disease	O Yes O No
Convulsions	O Yes O No	Mitral Valve Prolapse	O Yes O No
Cortisone Medicine	O Yes O No	Osteoporosis	O Yes O No
Diabetes	O Yes O No	Pain in Jaw Joints	O Yes O No
Drug Addiction	O Yes O No	Parathyroid Disease	O Yes O No
Easily Winded	O Yes O No	Psychiatric Care	O Yes O No
Emphysema	O Yes O No	Radiation Treatments	O Yes O No
Epilepsy or Seizures	O Yes O No	Recent Weight Loss	O Yes O No
Excessive Bleeding	O Yes O No	Renal Dialysis	O Yes O No
Excessive Thirst	O Yes O No	Rheumatic Fever	O Yes O No
Fainting/Dizziness	O Yes O No	Rheumatism	O Yes O No
Frequent Cough	O Yes O No	Scarlet Fever	O Yes O No
Frequent Diarrhea	O Yes O No	Shingles	O Yes O No
Frequent Headaches	O Yes O No	Sickle Cell Disease	O Yes O No
Genital Herpes	O Yes O No	Sinus Trouble	O Yes O No
Glaucoma	O Yes O No	Spina Bifida	O Yes O No
Hay Fever	O Yes O No	Stomach Disease	O Yes O No

Stroke	○ Yes ○ No	Tumors or Growth	○ Yes ○ No
Swelling of Limbs	○ Yes ○ No	Ulcers	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _______________

Comments ____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN __________________ DATE _______________

New Patient Questionnaire

1. How do you perceive your oral health? ○ Excellent ○ Good ○ Fair

2. When did you last seek dental treatment and for what reason? ____________________
____
____
____

3. Please mark or list any concerns about your oral health so that we may focus our exam to better serve you.

○ Tooth Pain
○ Bad Breath
○ Dry Mouth
○ Replacing Teeth
○ Straightening Teeth
○ My teeth need to be whiter
○ Bleeding Gums
○ Grinding Teeth at Night
○ Snoring or Sleep Apnea
○ Other ____
____
____

4. How did you learn about Seale Family Dental?

○ Facebook
○ Google
○ Family, Friend, or Neighbor ____
○ Other ____

5. In the future how would you like to be reminded of your appointment?

○ E-mail
○ Text
○ Phone Call

Patient HIPAA Consent Form

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing them competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this ___________________________ day of _____________________________20 _______
Print Patient Name____
Signature ____
Relationship to Patient ____

Consent for Services and Financial Policy

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

As a courtesy to you we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

An interest charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, 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 to discuss this statement or my treatment.

Signature ____

Date ____