# Patient Information **Appalachian Dental Associates**

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ SS#: _____ Sex: _____

Full Mailing Address: _____

Email address: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Who can we thank for referring you? _____

Employer: _____

Previous Dental Visit: _____ Previous Dental Cleaning: _____

**Responsible Party (if patient is minor)**

Name: _____ Date of Birth: _____

**Emergency Contact Information**

Name: _____ Phone#: _____

## Insurance Information

Dental Insurance: _____

☐ Through Employer or ☐ Individual Policy

SS# or Member ID#: _____ Group#: _____

**Policy Holder Information**:

Relationship: _____ Name: _____

Date of Birth: _____ SS#: _____

Mailing Address: _____

In regard to Privacy, I understand that Appalachian Dental staff may use or disclose personal health information for the purposes of carrying out treatment, specialty referrals, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that any request will be considered on a case by cases basis, but Appalachian does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Appalachian Dental Privacy Practices. I have been offered a copy of Privacy Practices. I have read, understand and agree to these policies.

_____ _____

Signature of Patient /Responsible Party Date

# MEDICAL HISTORY

PATIENT 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 dentistry 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 _____
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: _____

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

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

# Appalachian Dental Associates

## HIPAA FORM

Name of Patient_____Date of Birth _____

Appalachian Dental is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

| **Check each person/entity approved to receive information.** | Check type of information that can be given to person/entity on the left in the same section. |
|---|---|
| ☐ Voice Mail | ☐ Appointment reminders<br>☐ Financial |
| ☐ Other person (s) (provide name and phone number) | ☐ Financial<br>☐ Appointment reminders<br>☐ Tx |
| ☐ Email communication-Provide email address*<br>_____<br>*For email communication to occur, please accept the disclosure below: | ☐ Financial<br>☐ Tx<br>☐ Appointment reminders |
| ☐ Text communication – Provide number *<br>_____<br>*For text communication to occur, accept the disclosure below: | ☐ Appointment reminder<br>☐ Other: _____ |
| ☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. | |
| ☐ Photo taken by staff (Example: pre/post procedure)<br>☐ May be posted in office<br>☐ May be posted on website | |

**Patient Rights:**

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

# Payment & Financial Agreement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy. We offer the following methods of payment:

- **Payment in full** is due at the time of service. Cash, Check, Debit Card, MasterCard, Visa, Discover and American Express accepted.
- For patients with insurance, we will accept payment directly from the insurance company, but require that the deductible and non-covered fees be paid at each visit.
- We collaborate with Care Credit for a financing option. Applications can be completed online at www.carecredit.com or in office with the assistance of our receptionists. If approved, print off approval with our account number and bring to your appointment.
- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for child's co–payment.
- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow Appalachian Dental Associates to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.
- Fees quoted are good for up to 90 days.

**Important Information Regarding Your Dental Benefits**

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.
- **You** (not the insurance company) are responsible to us for all our fees for services rendered to you.
- An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.
- **BROKEN/MISSED APPOINTMENT:** Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for you convenience and hold great value. We require 48-hour notice of canceling or rescheduling your appointment, if 48 hours' notice is not given a $45.00 fee will be charged.

**I acknowledge I have received and agreed to Appalachian Dental Associates Payment & Financial Policies.**

**Patient or Responsible Party: _____**

**Date: _____ Relationship to Patient: _____**

# Appalachian Dental Associates

## Office Policies and Privacy Practice Agreement

It is required that you read and sign this form before any treatment.

- No one is permitted in treatment room except patient.
- Even though we have done our best to provide a thorough examination and treatment recommendation, additional conditions may be discovered at subsequent visits either with the Doctor or Hygienist as debris are removed or other services are performed.
- In order to avoid interruption in our work with patients, our front desk staff has been given the responsibility for making appointments and the collection of fees and accounts. Please consult them concerning these matters.

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I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

In regard to Privacy, I understand that Appalachian Dental staff may use or disclose personal health information for the purposes of carrying out treatment, specialty referrals, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that any request will be considered on a case by cases basis, but Appalachian Dental does not have to agree to requests for restrictions.

_____ _____

Signature of Patient /Responsible Party Date