DATE _____

NAME _____ _____
(LAST) (FIRST) (MI) SPOUSE / PARENT / GUARDIAN (CIRCLE ONE)

ADDRESS _____ CITY _____ ST ____ ZIP _____
(NO P.O. BOXES)

HOME PHONE _____ DATE OF BIRTH _____ SEX _____ SS# _____

CELL _____ BEST# TO REACH YOU: _____ DL# or ID #: _____

PLACE OF EMPLOYMENT _____ PHONE _____ OCCUPATION _____

EMAIL: _____

EMERGENCY CONTACT: _____ _____ PHONE: _____
RELATIONSHIP

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

MEDICAL HEALTH

PHYSICIAN _____ ADDRESS _____ PHONE # _____

Date of last physical exam: _____ Are you in good health? _____

Have you been under a physician's care during the last 2 years? _____ For? _____

Have you had major surgery? _____ What type? _____

List all current prescription medications you are taking: _____

_____

Are you allergic to: Penicillin _____ Codeine _____ Local anesthetics _____ Other _____

If female: Are you taking hormones or birth control? _____ or are you pregnant or nursing? _____

WHEN WAS YOUR LAST DENTAL CHECK-UP? _____ DENTAL X-RAYS _____

How do you feel about your smile: _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

AIDS or HIV Infection
ABNORMAL BLOOD PRESSURE
ALCOHOLISM
ALZHEIMERS / DEMENTIA
ANEMIA
ANOREXIA/BULIMIA
ARTHRITIS
ASTHMA
DO YOU CARRY AN INHALER? _____
BRONCHITIS, EMPHYSEMA, COPD
CANCER
WHAT TYPE? _____
WHEN? _____
RADIATION THERAPY / CHEMOTHERAPY
WHEN? _____
DIABETES TYPE I or II
DRUG DEPENDENCY
EPILEPSY
FAINTING
GLAUCOMA
HEPATITIS or LIVER DISEASE
WHAT TYPE ? _____
HERPES/COLD SORE
KIDNEY DISEASE
CARDIOVASCULAR DISEASE
MITRAL VALVE PROLAPSE
ANGINA
PACEMAKER
RHEUMATIC FEVER
HEART ATTACK
CONGESTIVE HEART FAILURE
HEART MURMUR
STROKE
MENTAL HEALTH DISORDERS
ORGAN TRANSPLANT
WHEN? _____
OSTEOPOROSIS
PERSISTENT SWOLLEN GLANDS IN NECK
PROLONGED COUGH
SEXUALLY TRANSMITTED DISEASE
SINUS TROUBLE
TOBACCO USE
THYROID DISEASE
TUBERCULOSIS
ULCERS
ACID REFLUX / HEARTBURN
MULTIPLE SCLEROSIS

Joint Replacement YES or NO
Date: _____

Do you have any previous disease, condition or problem not previously listed?

_____

_____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

	YES	NO
DO YOU TAKE A BLOOD THINNER OR DAILY ASPIRIN? IF SO WHAT? _____	____	____
PROLONGED BLEEDING/ HEMOPHILIA	____	____
Artificial (prosthetic) heart valve	____	____
Previous infection endocarditis	____	____
Damaged valves in transplanted heart	____	____
Congenital heart disease (CHD)	____	____
Unrepaired cyanotic CHD	____	____
Repaired (completely) in last 6 months	____	____
Repaired CHD with residual defects	____	____

Except for the conditions listed above antibiotic prophylaxis is no longer recommended.

Has your physician or a previous dentist recommended that you take antibiotics prior to your dental treatment? YES or NO

If so what do you take?

_____

Name of doctor making recommendation?

_____

Doctor's Phone# _____

(PLEASE SEE OTHER SIDE)

FINANCIAL POLICY

We are pleased to serve you as your dental care provider. Please review our Financial Business Policy carefully and sign/initial all areas below.

_____ **All payments are due at Time of Service:**

INITIALS

We accept cash, personal check, or all major credit cards. A fee will be charged for all returned checks. Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

_____ **Regarding Insurance:**

INITIALS

As a courtesy for those with dental insurance, we will apply for payment with your insurance carrier; however, we request your **estimated** portion be paid at time of treatment. This office **cannot** guarantee how much your insurance company will pay. Regardless, you are responsible for payment. We act as a mediator as a courtesy to you, but cannot enter into dispute with an insurance company over payment.

Please provide the following information:

Insurance Carrier Name: _____

Address: _____ **Insurance Phone #**_____

_____

Employee Name: _____

SS#: _____ **ID #:** _____ **DOB:** _____

Group #: _____ **Employer:** _____

_____ **Insurance information:**

INITIALS

It is the patient's responsibility to inform our office of all changes in insurance company or information in order to prevent billing errors, denials or delays.

_____ **Missed Appointments:**

INITIALS

If you are unable to keep an appointment please call our office to reschedule at least 24 hours in advance otherwise your account will be subject to a $50 cancellation fee.

Please help us to serve our patients better by keeping scheduled appointments. We consider all appointments as confirmed. Our reminder calls, emails or text messages are a courtesy to our patients. We reserve the right to dismiss patients that miss three or more appointments.

TREATMENT AND RELEASE

(PLEASE READ CAREFULLY)

I certify that I have read and understand the above information to the best of my knowledge. The previous questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or health practitioners. If applicable I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for services rendered on my behalf or my dependents.

I hereby give consent for examination and treatment by Joseph R. Craig, D.D.S. or R. Andrew Powless, D.M.D.

X _____ DATE: _____

SIGNATURE OF PATIENT OR GUARDIAN/PARENT (IF MINOR)

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

As part of my health care, the practice originates and maintains paper and/or electronic 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 to communicate with health professionals who contribute to your care.
- A source for applying your diagnosis and treatment information for payment purposes.

ACKNOWLEDGEMENT

I have been provided with a copy and the opportunity to read the "*Patient Health Information Privacy Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to read the **"Patient Health Information Privacy Practices"** prior to signing this consent,
- The right to request a copy of the **"Patient Health Information Privacy Practices"** for my own use.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

PATIENT'S NAME: _____

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation:
Example: spouse (name), children (names), other relatives (names), friends or caregivers (names)

_____

_____

Messages or Appointment Reminders:

May we call your **home** using doctor's/practice name: Yes [ ] No [ ]
If yes, may we leave a message Yes [ ] No [ ]
May we call your **work** using doctor's/practice name: Yes [ ] No [ ]
If yes, may we leave a message Yes [ ] No [ ]

Messages will be of a non-sensitive nature, such as, appointment reminders.

I fully understand, acknowledge and accept this consent.

_____ Signature_____
Print name of person signing

_____
Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations.
Yes [ ] No [ ]

FOR OFFICE USE ONLY

[ ] " Consent form" reviewed by (employee) _____ on (date) _____
[ ] Patient refused to sign the consent form.
[ ] Reason for patient refusal to sign _____
[ ] Restrictions were added by the patient (see restrictions listed above) _____