



DENTAL CARE OF PEARLRIDGE

Patient's Name _____

Last First Middle

Marital Status: Single _____ Married _____

Date of Birth _____ Female _____ Male _____

Social Security# _____

How do you wish to be addressed? _____

Home Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____

Cell# _____ Email _____

May we contact you (and leave messages) at the above phone numbers to confirm appointments? Y / N

If not, please specify appropriate phone numbers _____

Who is responsible for this account? _____

Relationship to patient: _____

Primary Dental Ins: _____

Subscriber: _____ Subscriber birthdate: _____

Secondary Dental Ins: _____

Subscriber: _____ Subscriber birthdate: _____

Whom may we thank for this referral? _____

Person to notify in case of emergency: _____

Relationship to patient: _____ Ph#: _____

INFORMED CONSENT:

1. Work to be done
a. I understand that as a part of an examination at Dental Care of PearlrIDGE ("DCP"), x-rays are required to properly diagnose my (or my child's) oral condition. If, however: (i) I refuse to take any x-rays (or not allow my child to take any x-rays) at DCP, or (ii) I do not provide DCP with x-rays approved by DCP, I understand that DCP will not be able to complete a full examination on me (or my child) and they will not be able to render an accurate diagnosis of my (or my child's) oral condition. I understand if I choose not to take any x-rays (or not allow my child to take any x-rays) and still proceed with treatment for myself (or my child) at DCP, it will be done at my own risk.

Initials: _____

2. Broken appointments
a. When I schedule an appointment for myself (or my child) at DCP, a specific amount of time will be reserved especially for me (or my child). If, however, I must re-schedule my (or my child's) appointment, I understand that I must inform DCP at least 48 (forty-eight) hours in advance.

Initials: _____

3. Dental record request
a. I understand that if I request that duplicate copies of my (of my child's) dental records and/or x-rays to be printed and sent to another General Dentist, I will be charged a \$25.00 fee that will be due upon such request.

Initials: _____

4. Receipt of Notice of Privacy Practices
a. I have received and/or read and understand DCP's Notice of Privacy Practices for myself (or my child's).

Initials: _____

RELEASE:

I authorize Dental Care of PearlrIDGE ("DCP") to perform diagnostic procedures/treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) healthcare, advice, and/or treatment provided for the purpose of evaluating and/or administering claims for insurance benefits.

I authorize payment of insurance benefits directly to a doctor at DCP and/or DCP, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and that I am responsible for payments in full for all accounts. By signing this document, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

I agree that a service charge of 2% per month, 18% APR, will be added to balances over 30 days. I agree that I am liable for all legal and collection fees, which include an additional 50% of past due balances, and that accounts that are 60 days past due may be referred to a collection agency.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature: _____ **Date:** _____

Patient's Name _____
 Last First Middle Date of Birth

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you allergic to, or have had any reactions to any of the following: | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetics (e.g. Novocaine, etc....) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medications are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Barbituates | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken Bisphosphonates (e.g. Fosamax) to treat Osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> | Asprin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any metals (e.g. nickel, mercury, etc....) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) _____ | | |
| | | | 10. Women only: | | |
| | | | a. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b. Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c. Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | Yes | No | | Yes | No | | Yes | No |
|-----------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| ARC | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorder | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain disorder | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B, or C | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Severe headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | HIV | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Injury to face or head | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital defect | <input type="checkbox"/> | <input type="checkbox"/> | Jaw lock (couldn't open or close) | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Jaw popping or clicking | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear pain | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | Transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Veneral disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever blisters | <input type="checkbox"/> | <input type="checkbox"/> | Organ transplants | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | |

PATIENT DENTAL HISTORY

- | | Yes | No | | Yes | No |
|-------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever had any difficult extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you wear dentures or partials? If yes, specify date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 9. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Any other questions and/or concerns _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____



DENTAL CARE OF PEARLRIDGE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR DENTAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Dental Care of PearlrIDGE uses health information about you for treatment, payment and health care operations. Your health information is contained in paper and electronic records that are the property of Dental Care of PearlrIDGE.

Use or Disclosure of Your Health Information

For Treatment:

Dental Care of PearlrIDGE may use your health information to provide you with dental treatment and services. For example, information obtained by Dental Care of PearlrIDGE will be included in your dental records that is related to your treatment. This information is necessary for Dental Care of PearlrIDGE to determine what treatment you should receive. Dental Care of PearlrIDGE will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment:

Dental Care of PearlrIDGE may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a claim may be sent to your insurance carrier from Dental Care of PearlrIDGE, in order for your insurance carrier to make payment based upon your dental benefits coverage. The information on the claim will include information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

For Health Care Operations:

Dental Care of PearlrIDGE may use and disclose health information about you for operational purposes. For example, your dental information may be disclosed to your dental insurance carrier to:

- Evaluate the performance of your dentist;
- Assess the quality of care and outcomes in your cases and similar cases; and
- Learn how to improve our services to you.

Appointments:

Dental Care of PearlrIDGE may use your information to provide appointment reminders or information about treatment alternatives or other dental-related benefits and services that may be of interest to you.

Required by Law:

Dental Care of PearlrIDGE may use and disclose information about you as required by law. For example, your dentist may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Public Health:

Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

Decedents:

Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation:

Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research:

Dental Care of PearlrIDGE may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety:

Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions:

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of protected health information.

Workers Compensation:

Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses or disclosures of your protected health information, however, your dentist is not required to agree to a requested restriction.
- Obtain a paper copy of the Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your dental records held by Dental Care of PearlrIDGE upon request.
- Request to amend your dental records.
- Request communications of your dental information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose dental information except to the extent that action has already been taken.
- Receive an accounting of disclosures made of your information by Dental Care of PearlrIDGE.

Complaints

You may submit complaints to Dental Care of PearlrIDGE, insurance carrier and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Your Dentist

Your dentist is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to you health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Your dentist reserves the right to change its privacy practices and to make new provisions effective for all protected health information it maintains. As notices are revised, copies will be mailed to you within sixty (60) days of making the change.

If you have any questions or complaints, or if you do not want to provide your consent to your dentist, to use your protected health information for purposes of payment and/or health care operations, please submit a letter of denial to provide consent to our office.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Dental Care of PearlrIDGE’s Notice of Privacy Practices for myself /
(Name of Patient or Parent/Legal Guardian)

If patient is under 18, name of patient

Please Print Patient or Parent/Legal Guardian Name

Patient or Parent/ Legal Guardian Signature Date

For Office Use Only

Individual has signed the written Acknowledgement of Receipt of our Notice of Privacy Practices.

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (please specify): _____

Dental Office Signature: _____ Date: _____