Spruce Dental

PATIENT INFORMATION DATE_____

Name_____ Sex: M____ F____ Birthdate_____

Social Security #_____ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Email_____ Driver License #_____

When confirming appointments, how do you prefer to be contacted? Phone_____ Email_____ Text_____

Employer_____ Work Phone_____

May we contact you at work? _____ Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

In case of emergency, who should be notified? _____ Phone #_____

How did you hear about our office? _____

PRIMARY INSURANCE

Person responsible for account_____ Relation to patient_____

Employer_____ Birthdate_____ Social Security #_____

Address (if different from patients)_____ Phone #_____

City_____ State_____ Zip Code_____

Insurance Company_____

ID#_____ Group #_____

Name other dependents covered under this plan_____

DENTAL HISTORY

Name of previous dentist/location_____ Date of last exam/cleaning_____

What would you like to change about your smile? _____

OFFICE POLICIES

I understand that payment is expected at time services are rendered. If I have dental insurance, I authorize payment directly to the doctor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that deductibles and copays are due on the date of service. The office does its best to give me the accurate estimate of my benefits. I know that insurance companies do not guarantee benefits over the telephone. I understand that I am responsible for knowing the coverage and benefits of my insurance policy. If my insurance company does not pay my claim as expected. I understand that the responsible party is obligated for the balance of the account. I understand that if my account must get turned over to a collection agency that I am responsible for a $30 late fee.

Signature of Patient or Parent if Minor_____ Date_____

DENTAL MEDICAL HISTORY FORM

Patient Name:_____ Birthdate:_____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Is the patient under a physician's care now? ☐ Yes ☐ No If yes_____
Has the patient ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes_____
Is the patient taking medications? ☐ Yes ☐ No If yes_____
Does the patient take any osteoporosis medications? (Fosamax) ☐ Yes ☐ No If yes_____
Does the patient use tobacco? ☐ Yes ☐ No If yes_____
Please list prior hospitalizations/surgery/illnesses _____

Women Only: Are you? ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

ADD/ADHD	☐Yes ☐No	Easily Winded	☐Yes ☐No	Lung Disease	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Emphysema	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy/Seizures	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Angina	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Anxiety Disorder	☐Yes ☐No	Fainting/Dizziness	☐Yes ☐No	Radiation	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Frequent Headache	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial joints	☐Yes ☐No	Herpes	☐Yes ☐No	Rheumatism	☐Yes ☐No
Asthma	☐Yes ☐No	Hay Fever	☐Yes ☐No	Shingles	☐Yes ☐No
Autism	☐Yes ☐No	Heart Failure	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Blood Disease	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Pacemaker	☐Yes ☐No	Stomach Disease	☐Yes ☐No
Breathing Issues	☐Yes ☐No	Heart Disease	☐Yes ☐No	Special Needs	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Hep A	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Cancer	☐Yes ☐No	Hep B or C	☐Yes ☐No	Stomach Disease	☐Yes ☐No
Chemotherapy	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stroke	☐Yes ☐No
Chest Pains	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Cold Sores	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Tonsilitis	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Diabetes I	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Tumors/Growths	☐Yes ☐No
Diabetes II	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Ulcers	☐Yes ☐No
Down Syndrome	☐Yes ☐No	Leukemia	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Liver Disease	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No

*If heart murmur, does the patient require antibiotics prior to dental treatment? ☐Yes ☐No
*If epilepsy or seizures, date of last seizure? _____
*Does the patient have any illnesses not listed above? _____

ALLERGIES (Please check all that apply) ☐Aspirin ☐Penicillin ☐Codeine ☐Latex ☐Acrylic ☐Metal ☐Local Anesthetic
Other Allergies? If yes_____

HABITS (Please check all that apply) ☐Thumb Sucking ☐Lip Biting ☐Nail Biting ☐Grind Teeth ☐Clench Jaw

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

X_____ _____
Signature of Patient Date

This form has been reviewed with Patient, Parent, or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date

HIPAA PATIENT CONSENT FORM

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form. This Act gives you, the patient, rights to understand and control how your health information is used.

We may disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means provided, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing and utilization review.
- Health care operations include business aspects of running our practice, such as auditing functions, cost management, and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise with a written request to the office manager.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your notice of privacy practices description and disclosure of my protected health information.

_____

Patient Name

_____

Patient Signature Date

Medications

Patient Name: _____ Date of Birth: _____

( ) I do NOT currently take any medications

( ) Copy of medications list provided to the front desk

Please list all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins, and minerals:

_____

_____

Patient Sign Date