PATIENT INFORMATION

CONFIDENTIAL Date _____

(PLEASE PRINT)

Name _____ Birth Date _____ Home Phone _____

Preferred Name _____ Cell Phone _____

Address _____ City _____ State_____ Zip _____

Circle One: Married Single Other

If patient is a minor, name of person responsible for this account _____

Relationship to patient _____

Patient or parent/guardian driver's license# _____ S.S.# _____

Person to contact in case of emergency_____ Phone_____

Whom may we thank for referring you to our practice? _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for this account

Name _____

Employer Name_____ Occupation_____

Address _____ City _____ State_____ Zip _____

Work Phone_____

SIGNATURE

I certify that I have read and understand the information on both sides of this form. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information could jeopardize my health. I authorize and request my insurance company to pay directly to the dentist or dental group insurance 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 of all services rendered, late fees, or interest charges incurred on my behalf or on behalf of my dependents.

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

PATIENT NAME_____ BIRTH DATE _____ DATE_____

DENTAL HISTORY

	YES	NO
Do you have a specific dental Problem? Describe: _____	☐	☐

When was your last dental visit? _____
What was done at that time? _____
If last visit was not cleaning, when was last cleaning? _____
Have you had, or do you currently have, any of the following? (check appropriate boxes)

☐ dental extractions	☐ partial or full denture	☐ jaw popping/clicking/discomfort
☐ gum surgery	☐ dental implant	☐ food catching in teeth
☐ bleeding gums/gum disease	☐ loose teeth	☐ chipped teeth
☐ bridge	☐ bruxing / grinding	☐ orthodontic work

	YES	NO
Do you use any form of tobacco? (specify) _____	☐	☐
Do you consume alcoholic beverages? _____	☐	☐
Have you had any trouble associated with any previous dental treatment? Explain: _____	☐	☐

MEDICAL HISTORY

	YES	NO
Name of Primary Physician_____		
Office Phone _____ Date of last exam _____		
Have you ever been hospitalized or had an operation? Explain:_____	☐	☐
Have you ever had a serious injury to your head or neck? Explain: _____	☐	☐
Are you taking any medications, pills, or drugs?	☐	☐

Please list: Medication Reason for taking

_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR MATERIALS? List: _____	☐	☐

WOMEN: (please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Have you had, or do you currently have, any of the following? (check appropriate boxes)

☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Emphysema	☐ Nervousness
☐ Heart Murmur	☐ Anemia	☐ Tuberculosis	☐ Kidney Problems
☐ Irregular Heart Beat	☐ Excess Bleeding	☐ Cancer	☐ Thyroid Disease
☐ Angina/Chest Pain	☐ Sickle Cell Anemia	☐ Radiation Therapy	☐ Arthritis/Gout
☐ Heart Attack/Failure	☐ Hemophilia	☐ Chemotherapy	☐ Rheumatism
☐ Congenital Heart Defect	☐ Leukemia	☐ Stomach/GI Problems	☐ Pain in Jaw Joints
☐ Mitral Valve Prolapse	☐ Blood Transfusion	☐ Diabetes	☐ Artificial Joint
☐ Artificial Heart Valve	☐ Breathing Problem	☐ Liver Disease	☐ Venereal Disease
☐ Heart Pace Maker	☐ Frequent Cough	☐ Hepatitis Type ____	☐ HIV Positive
☐ High Blood Pressure	☐ Hay Fever	☐ Back/Neck Pain	☐ Drug Addiction
☐ Stroke	☐ Sinus Trouble	☐ Hearing Problems	☐ Cold Sores
☐ Epilepsy/Seizures	☐ Asthma	☐ Glaucoma	☐ Implants
☐ Fainting/Dizziness	☐ Alzheimer's	☐ Tumors/Growths	☐ Shunts/Catheters

	YES	NO
Have you ever had any serious illness or condition not listed above? Describe:	☐	☐
Do you wish to talk to the dentist privately about any problem? _____	☐	☐

Burlingame Family Dentistry
Rebecca K. Morisse, DMD

FINANCIAL POLICIES

Please initial by each policy statement to indicate you understand our office financial policies.

_____ Payment is expected the day services are rendered unless prior financial arrangements have been made.

_____ A charge will be made for broken, missed, or rescheduled appointments without 24 hours notice.

_____ As a courtesy to our patients, we will bill your dental insurance for you. Your dental insurance is a contract between you or your employer and the insurance company. We serve as an outside party that will bill the insurance company for you. You are responsible for all fees incurred.

_____ We will provide a treatment estimate for procedures prescribed by your dentist. Procedures needed and fees incurred are subject to change. We make every effort to formulate an accurate and appropriate treatment plan for each patient, but the required procedures to treat your teeth may change upon commencement of treatment.

I have read and agree to follow these financial policies for Burlingame Family Dentistry.

_____ _____

Patient Signature Date

Burlingame Family Dentistry
Rebecca K. Morisse, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received and reviewed a copy of the Notice of Privacy Practices for Burlingame Family Dentistry.

_____

Print PATIENT Name

_____

PATIENT Signature or Parent/Guardian Signature Date

For Office Use Only

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This can include, but is not limited to, calling in prescriptions to your pharmacy, discussing your case with specialists to whom we have referred you, and sending your x-rays to other dental offices involved in your dental treatment.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

_____

PATIENT Signature or Parent/Guardian Signature Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.