

DENTAL ASSOCIATES



GREEN STREET

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Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex (M/F) \_\_\_\_\_ Marital Status \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

**DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING:**

- Are you or have you been under the care of a physician?  Yes  No
- Are you taking or have you been taking any drugs or medications?  Yes  No
- If so, What?
- Are you allergic or have reacted to any drugs or medications?  Yes  No
- If so, What?
- Do you have a heart condition?  Yes  No
- Do you have high or low blood pressure?  high  low  N/A
- Do you have any lung conditions?  Yes  No
- Is there a history of diabetes in your family?  Yes  No
- Have you had Rheumatic fever or Heart Murmur?  Yes  No
- Do you have any artificial joints or heart valves?  Yes  No
- Do you have a mitral valve prolapse?  Yes  No
- Have you had Hepatitis?  Yes  No
- Have you had venereal disease?  Yes  No
- Have you ever had a blood transfusion?  Yes  No
- Have you ever been exposed to the AIDS virus?  Yes  No
- Have you had kidney failure or are you on dialysis?  Yes  No
- Have you ever had any liver problems?  Yes  No
- Have you ever had cancer or radiation therapy?  Yes  No
- Have you ever had any bleeding problems?  Yes  No
- Do you have sinus or allergy problems?  Yes  No
- Do you have any emotional problems?  Yes  No
- Women are you pregnant?  Yes  No
- Is there any other condition we should be aware of?  Yes  No
- If so, What?
- Are your teeth sensitive to hot, cold or sweets?  Yes  No
- Do you grind or clench your teeth?  Yes  No
- Do your gums bleed when you brush?  Yes  No
- Do you have regular dental checkups?  Yes  No
- Do you smoke or chew tobacco?  Yes  No

Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Billing & Insurance Information

Name of Responsible Billing Party \_\_\_\_\_

Billing Address \_\_\_\_\_

Referred By \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Medical Insurance (Y/N) \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Dental Insurance (Y/N) \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

*(Please provide the Receptionist with a copy of both your Medical and Dental Ins. Cards)*

## HIPPA Consent Form

I understand that, under the Health Portability & 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 directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Green Street Dental Associates of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_