DAY DENTAL CARE

Patient Last Name: ______________________ First Name: ____________________ MI: ________

(❑ Single ❑ Married ❑ Divorced ❑ Seperated ❑ Widowed) (❑ Male ❑ Female) DOB ________

Address ____

City ______________ State ______________ Zip ______________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

E-Mail ______________ Employer ______________ Insured Name: ______________

Social Security #: ______________ Dental Insurance Co. ______________

Group #: ______________ Member ID #: ______________ Drivers License #: ______________ Exp: ______

How did you hear about our practice? Patient / Friend: ______________ Staff Member: ______________ Doctor: ______________

Insurance Company ______ Search Engine: ______ Facebook ______ Twitter ______ Blog ______ Other: ______

RESPONSIBLE PARTY

Last Name ______________ First ______________ MI ______________

Address ______________ City ______________ Zip ______________

DOB ______________ Social Security # ______________

Home Phone ______________ Work Phone ______________ Mobile Phone ______________

EMERGENCY CONTACT

Last Name ______________ First ______________ Phone # ______________

Address ____

AUTHORIZATION- *Please Read This Carefully & Initial Each Topic*

______ Day Dental Care provides insurance company billing as a courtesy to our patients. The patient portion of your services are estimated and due at the time of service. Any amount that is not paid by your insurance company is due by you. In addition, certain insurance companies have annual limitations which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for these charges in full.

______ The claims we submit to insurance companies indicate that you have assigned these benefits to Day Dental Care. However, if you are paid by the insurance company instead of Day Dental Care, you then become responsible for the total account balance and payment would be expected immediately. You as a patient are always responsible for any charges that are not covered by your insurance company.

______ We understand that emergencies arise that preclude you from keeping an appointment, but ***PLEASE*** remember that we have reserved an appointment time especially for you. We request that you give us at least a 24 hour notice to reschedule an appointment. Therefore a missed appointment fee of **$52.00** will be assessed if 24 hour notice is not given for changing or cancelling a reserved appointment.

Signature ____ Date ______________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

DATE: ______________________________ PATIENT NAME: ______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITYS IN THE FUTURE.

___________________________________ ___________________________________

Please ***Print*** your name Please ***Sign*** your name

___________________________________ ___________________________________

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

□ First Name Only □ Last Name Only □ Other: ______________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________________________ Relationship: ___________________________

Name: ______________________________ Relationship: ___________________________

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

□ Cell Phone Confirmation □ Text Message to my Cell Phone
□ Home Phone Confirmation □ E-Mail Confirmation
□ Work Phone Confirmation □ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Cell Phone Confirmation □ Text Message to my Cell Phone
□ Home Phone Confirmation □ E-Mail Confirmation
□ Work Phone Confirmation □ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representative) signature on this Acknowledgement but did not because:

It was emergency treatment. __________
I could not communicate with the patient. __________
The patient refused to sign. __________
The patient was unable to sign __________
Other: ____________________________ __________

______________________________________ ______________________

Signature of Privacy Officer Date

HEALTH HISTORY

PATIENT NAME: ________________________________ DATE OF BIRTH: ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No DR'S NAME? ____________________
Have you ever been hospitalized/or major surgery? ☐ Yes ☐ No WHY & DATE? ____________________
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ***IF "YES" FILL OUT BACK OF SHEET***
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No WHAT & DATE? ____________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No WHAT & DATE? ____________________
Are you on a special diet? ☐ Yes ☐ No WHAT KIND? ____________________
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you ☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? CHECK FOR YES

☐ Aspirin ☐ Penicillin ☐ Amoxicillin ☐ Erythromycin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa Drugs ☐ Advil ☐ Tylenol ☐ Food Allergies ____________________ ☐ Other ____________________

PLEASE CHECK ANY OF THE BELOW CONDITIONS YOU HAVE EVER HAD OR HAVE NOW

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis / Gout
☐ Artificial Heart Valve
☐ ****Artificial Joint ****

***** PRE-MEDICATION MAY BE NECESSARY *****

WHERE? ____________________

WHEN? ____________________

DR NAME: ____________________

PHONE #: ____________________

We will need to contact your Dr to get your Pre-Med regimen.

☐ Asthma
☐ Blood Disease

☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores / Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/ Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Glaucoma

☐ Hay Fever / Allergies
☐ Heart Attack / Heart Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes / Genital Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints

☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach / Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A ____________________

I ACKNOWLEDGE THAT I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT BY NOT DOING SO IT CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE AND DR OF ANY CHANGES IN MY MEDICAL STATUS PRIOR TO ANY TREATMENT.

______________________________ ______________________________
Signature of Patient, Parent, or Guardian Date

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS THAT YOU ARE TAKING:

ADHD	CONGESTIVE HEART FAILURE	OSTEOPOROSIS
ADDERALL – AMPHETEMINE	COREG – CARVEDILOL	ACTONEL – RISEDRONATE
CONCERTA – METHYLPHENIDATE	LANOXIN - DIGOXIN	BONIVA – IBANDRONATE
VYVANSE - LISDEXAMFETAMINE		FOSAMAX – ALENDRONATE
STRATTERA - ATOMOXETINE	**DIABETES**	RECLAST (INJECTION)
	GLUCOPHAGE – METFORMIN	RECLAST - ZOLEDRONATE
ALLERGIES	GLUCOTROL – GLIPIZIDE	EVISTA - RALOXIFINE
ALLEGRA – FEXOFENADINE	HUMULIN – INSULIN	**PAIN**
FLONASE – FLUTICASONE		ASPIRIN
FLOVENT - FLUTICASONE	**DIURETIC**	ADVIL – IBUPROFEN
NASONEX – MOMETASONE	HYDROCHLOROTHIAZIDE	ALEVE – NAPROXEN
PHENERGAN - PROMETHAZINE	LASIX – FUROSEMIDE	TYLENOL #2 – CODEINE/APAP
	MICARDIS – TELMISARTAN	LYRICA – PREGABALIN
ALZHEIMERS		MORPHINE
NAMENDA - MEMANTINE	**EPILEPSY**	MOBIC – MELOXICAM
	DILANTIN – PHENYTOIN	TOPAMAX – TOPIRAMATE
DEPRESSION/ANXIETY	LYRICA – PREGABALIN	ULTRAM - TRAMADOL
CELEXA – CITALOPRAM	NEURONTIN – GABAPENTIN	
CYMBALTA – DULOXETINE		**SEIZURES/TREMORS**
EFFEXOR – VENLAFAXINE	**G.E.R.D.**	MIRAPEX – PRAMIPEXOLE
LEXAPRO – ESCITALOPRAM	PRILOSEC – OMEPRAZOLE	TEGRETOL – CARBAMAZEPINE
PAXIL – PAROXETINE	NEXIUM – ESOMEPRAZOLE	
PRISTIQ – DESVENLAFAXINE	PEPCID – FAMOTIDINE	**STEROID**
PROZAC – FLUOXETINE	PROTONIX – PANTOPRAZOLE	PREDNISONE
ZOLOFT – SERTRALINE	ZANTAC – RANITIDINE	MEDROL DOSEPACK
ATIVAN - LORAZEPAM		
XANAX - ALPRAZOLAM	**GOUT**	**THYROID**
ASTHMA	ZYLOPRIM – ALLOPURINOL	CYTOMEL – LIOTHYRONINE
PROVENTIL – ALBUTEROL		LEVOXYL – LEVOTHYROXINE
ADVAIR – FLUTICASONE	**GLAUCOMA**	THYROLAR – LIOTRIX
SINGULAIR – MONTELUKAST	XALATAN - LATANOPROST	ARMOUR THYROID – THYROID
SYMBICORT – BUDESONIDE		SYNTHROID - LEVOTHYROXINE
FLOVENT - FLUTICASONE	**HIGH BLOOD PRESSURE**	
ARTHRITIS	BENICAR – OLMESTARTAN	**OVER THE COUNTER**
HUMIRA - ADALIMUMAB	DIOVAN – VALSARTAN	VITAMIN C
	LOPRESSOR – METOPROLOL	VITAMIN D
BLOOD THINNER	NORVASC – AMLODIPINE	MULTI VITAMINS
COUMADIN – WARFARIN	PRINIVIL – LISINOPRIL	FISH OIL
PLAVIX – CLOPIDOGREL	TENORMIN – ATENOLOL	ALLERGY MEDICATIONS
XARELTO – RIVAROXABAN	BYSTOLIC - NEBIVOLOL	B-12
	BETA BLOCKER - CARVEDILOL	SUPPLEMENTS
CHOLESTEROL		
CRESTOR – ROSUVASTATIN	**OTHERS (NOT LISTED):**	
LIPITOR – ATORVASTATIN		
NIASPAN – NIACIN		
PRAVACHOL – PRAVASTATIN		
ZOCOR - SIMVASTATIN		

_________________________ _________________________

PRINTED PATIENT NAME **DATE**

_________ **I TAKE NO MEDICATIONS EITHER PRESCRIBED OR OVER THE COUNTER AT THIS TIME.**

(INITIAL)