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Sensational Dental Care

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**And**

**Dental Materials Fact Sheet**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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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)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).



# Welcome

Thank you for selecting our Practice! We will strive to provide you  
With the best possible dental and business services. To help us  
Meet all of your needs please fill out this form completely. If you  
Have any questions please don't hesitate to ask.

1	Personal Information
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Name _____ Date _____
Birthdate _____ Soc. Sec. # _____
Nickname _____
___ Male ___ Female ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated
Address _____
City, State, Zip _____
Employer _____ Referred By _____

2	Responsible Party
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Who is responsible for the account? Name _____
Relationship to patient _____ Birthdate _____
Soc. Sec. # _____ Driver's License # _____
Address _____
City, State, Zip _____
Employer _____ Work Phone _____
Home Phone _____ Cell Phone _____

3	Telephone
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Home Phone _____ Cell Phone _____
Work Phone _____ Ext# _____ E-Mail _____
Best number to reach you at ___ Work ___ Home ___ Cell Best Time ___ Day ___ Night
In the event of an emergency who should we contact? Name _____
Relationship _____ Work # _____ Home# _____

## 4 Dental Insurance Information

### Primary Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthdate \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. Annual benefit \_\_\_\_\_

### Additional Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthdate \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. Annual benefit \_\_\_\_\_

## 5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

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 on my behalf or my dependents.

Signature of patient or parent if minor

\_\_\_\_\_ Date

## 6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment.

Cash  
 Personal Check  
 Credit Card  Visa  MC

I wish to discuss the dental office's policy.

### Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask—we are always happy to help.



# Health History

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Have you been under the care of a medical doctor during the past two years Yes No  
 If yes for what? \_\_\_\_\_  
 Physician's name \_\_\_\_\_ Phone number \_\_\_\_\_  
 Have you taken any medication or drugs in the past two year's Yes No  
 Are you taking any medication, drugs or pills now? Yes No  
 If yes, please list name(s) and dosage(s) \_\_\_\_\_

Are you aware of having any allergic or adverse reaction to any medication or substance? Yes No  
 If yes, please list: \_\_\_\_\_  
 Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had or have at present. ( Please circle YES or NO )

Heart ( Disease, Attack)	Y / N	Diabetes	Y / N	HIV/ Aids	Y / N
Chest Pain	Y / N	Thyroid Problems	Y / N	Cold Sores/Fever	Y / N
Congenital Heart Disease	Y / N	Glaucoma	Y / N	Bruise Easily	Y / N
Heart Murmur	Y / N	Emphysema	Y / N	Liver Disease	Y / N
Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N	Kidney Trouble	Y / N
Artificial Heart Valve	Y / N	Asthma	Y / N	Neurological Disorders	Y / N
Heart Pacemaker	Y / N	Allergies or Hives	Y / N	Epilepsy/Seizures	Y / N
Rheumatic Fever	Y / N	Hay Fever	Y / N	Fainting/Dizzy Spells	Y / N
High Blood Pressure	Y / N	Latex Sensitivity	Y / N	Nervous/Anxious	Y / N
Arthritis/Rheumatism	Y / N	Cancer Tumors	Y / N	Phen-Fen Use	Y / N
Cortisone Medicine	Y / N	Chemotherapy	Y / N		
Artificial Joints ( Hips,Knee Ect)	Y / N	Radiation Therapy	Y / N		
Ulcers	Y / N	Hepatitis ( A, B or C )	Y / N		

Do you have or have you had any disease, condition, or problem not listed? Yes No  
 If Yes please list \_\_\_\_\_  
 Do you smoke? Yes No If yes how much? \_\_\_\_\_  
 Do you take Tagamet or antacids? Yes No  
 Do you take herbal supplements/ medications? Yes No If yes list \_\_\_\_\_  
 Women: Are you pregnant? Yes No ( Mos.) Nursing? Yes No Birth Control Pills? Yes No

Are you happy with the appearance of your teeth? Yes No  
 If no, what would you like to change? \_\_\_\_\_  
 Any problems or concerns with your oral health (bleeding gums, sensitivity, ect.) Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

\_\_\_\_\_  
**Patient or Parent/ Guardian Signature** \_\_\_\_\_  
**Date**

History Review	
Dr's Signature _____	Date _____
Dr's Signature _____	Date _____
Dr's Signature _____	Date _____