Dalton Dental

www.daltondental.net
Admin@daltondental.net
4511 West Gandy Blvd • Tampa, FL 33611
(813)872-8300

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

When was your last cleaning? *
_____

How often do you get your cleanings? * _____

When was your last xrays? * _____

What are you interested in accomplishing (your goals) with your dental treatment? * _____

Did anyone refer you? * ◯ Yes ◯ No

If so, who?

Do you have any allergies? * ◯ Yes ◯ No

Do you need a pre-med? * ◯ Yes ◯ No

Any limitations to treatment? * ◯ Yes ◯ No

Have you ever been treated for periodontal or gum disease? * ◯ Yes ◯ No

Anything bothering you /chief complaint? * ◯ Yes ◯ No

Are you interested in having straight teeth? * ◯ Yes ◯ No

Are you interested in having whiter teeth? * ◯ Yes ◯ No

Are you interested in having less wrinkles? * ◯ Yes ◯ No

Are you interested in healthy glowing skin? * ◯ Yes ◯ No

Are you interested in younger looking skin? * ◯ Yes ◯ No

AS YOUR ELECTRONIC SIGNATURE, TYPE YOUR FULL NAME BELOW: *

Response Date: ____/____/_____

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Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

ELECTRONIC (E-MAIL) COMMUNICATION RELEASE:

I would like to communicate via e-mail with Dalton Dental on matters related to my health and or my dental treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of it's workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of it's workforce member liable for any loss of confidentiality associate with such transmissions. Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. The dental practice or its service provider may contact me to provide healthcare information such as an appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. *

◯ Yes ◯ No

If NO, please indicate your preferred method of contact and below your most up-to-date information. Our office sends out U.S. Mail on a limited basis. Please let us know your preferred mailing address, phone, and email address. Please always informe our office of any changes right away. Thanks. *

_____

PHOTOGRAPHY / TESTIMONY RELEASE:

I hereby authorize DALTON DENTAL to use, reproduce, and/or publish photographs and video testimonies that may pertain to me and my treatment--before and after photos, treatment photos including my image without compensation. I understand that this material may be used in various publications or for other related endeavors. This material may also appear on our Internet Web Page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, DALTON DENTAL may publish materials (photographs, testimonies and other media). *

◯ Yes ◯ No

ACKNOWLEDGEMENT: BY SIGNING BELOW, YOU ARE CONFIRMING THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES ON ELECTRONIC COMMUNICATION AND PHOTOGRAPHY / TESTIMONY RELEASE.

AS YOUR ELECTRONIC SIGNATURE, TYPE YOUR FULL NAME BELOW: *

_____

_____

Response Date: ____/____/_____

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Patient Name: _____ _____ ____ _____
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DENTAL BENEFITS COVERAGE DISCLAIMER: Dental Benefit estimates are based on the information provided by your dental benefits company. Pre-estimates for services are not submitted unless requested. Your treatment plan(s) 'Patient" column shows your estimated co-pays. As stated in your dental benefits guidelines: The insurance estimates are not a guarantee of payment. Claims are processed when received and paid according to your eligible benefits at the time services are rendered. We will ask for your estimated co-pays at each appointment and your plan pays a maximum dollar amount per benefit year. Please familiarize yourself with your benefit coverage. Services rendered are always the patient's responsibility. I give permission to bill my dental benefits company and to assign benefits to be paid directly to Dalton Dental. *

◯ Yes ◯ No

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Dalton Dental accepts cash, personal checks (in-state only), VISA, MasterCard, American Express and Discover. There is a $45.00 service charge for all returned checks. We are able to keep a credit card on file and give a courtesy call if balances due exceed $50.00 (in the event that there is a balance due after your insurance company has processed your claims). All accounts over 60 days past due will be charged up to 50% collection fee to the outstanding balance and submitted to our collection agency plus a collection agency penalty fee of $150.00. *

◯ Yes ◯ No

DELIQUENT PAYMENTS: We realize that financial difficulty is a reality. It is our policy to charge finance fees at 1.5% for outstanding patient balances over 30 days past due. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $45.00. Patients with an outstanding balance 30 days or more overdue must make arrangements for payment prior to scheduling appointments.
HSA Account Holders/Flexible Spending Accounts: As a courtesy, we will keep a credit or debit card, (HSA or Flexible spending card) on file and give a courtesy call if balances due exceed $50.00 (in the event that there is a balance due after your insurance company has processed your claims).
***

◯ Yes ◯ No

REFUNDS: Patient/guarantor credits in amounts less than $100.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $101.00 and greater patient will have choice to keep as credit or refund check. The refund checks are distributed by accounting every 60 days. *

◯ Yes ◯ No

CANCELLATION POLICY: ALL appointments are required 48 hours cancellation notice. This is done by calling the office ONLY. If 48 hour notice is not given then $50 fee is applied to patient's account plus additional fees and deposit fee is forfeited.

DEPOSITS ON PROCEDURE APPOINTMENT: ALL preocedure appoinments that are over $1000 must have 20% deposit placed. This deposit will be applied to procedure. If patient does not follow cancellation policy then deposit is forfeited and no refund of deposit. Your time is valuable and we want you to respect ours as well. *

◯ Yes ◯ No

MISSED APPOINTMENTS AND CANCELLATIONS: Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We require a 48 hour cancellation. If cancelled less than 48 hours, then your account will be charged a cancelation fee of $100 for hygiene recare, $100 for treatment visits, and $250 for surgery visits plus loss of 20% deposit required on all procedures above $1000. Excessive abuse of missed scheduled appointments will result in a deposit requirement to reserve an appointment or discharge from the practice. If appointment is broken less than 48 hrs in advance then the deposit is forfeited. Please help us service you better by keeping scheduled appointments.

*

◯ Yes ◯ No

DENTAL BENEFITS: As a courtesy, we bill primary participating dental benefits (insurance) companies. Your deductible, policy exclusion services, and co-payments are due at the time of service. If we have not received payment from your company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Unfortunately, we are not able to accept payment or submit claims for you from any secondary companies. We will give you all the information you need to submit at your initial visit. If you need assistance or have questions, please contact The Billing Coordinator between 8:30 a.m. and 5:00 p.m., Monday through Thursday at 813-872-8300. *

◯ Yes ◯ No

FINANCIAL RESPONSIBILITY: All payments are due at the time of the visit. I understand that if my dental benefit (Insurance) coverage has expired or lapsed, I will be responsible for payment in full. If my Insurance Company denies payment and does not pay within 35 days as required by the state law, I am responsible for payment in full. If dispute arises that cannot be settled amicable, the practice and patient agree to meet for mediation before filling any matters with the courts. The mediation location will be within Hillsborough County and at the sole discretion of the practice. The losing party, as determined by the mediator, will be responsible for all costs arising out of the mediation to include mediation, experts and attorney fees. If mediation cannot settle the case the place for any litigation will be Hillsborough County. All costs of the case including the attorney fees, witness expenses and court costs of the prevailing party will be the sole responsibility of the losing party. *

◯ Yes ◯ No

Responsible party for all payments and payment/financial guarantor?

AS YOUR ELECTRONIC SIGNATURE, TYPE YOUR FULL NAME BELOW: *

_____

_____

_____

Response Date: ____/____/_____

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Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEATLTH INFORMATION IS IMPORTANT TO US. ---------- OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 5, 2011, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose heath information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Patient Consent to Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations I understand that as part of my health care, Dalton Dental originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment. I understand that this information serves as: A basis for planning my care and treatment, ·A means of communication among health professionals who contribute to my care, ·A source of information for applying my diagnosis and surgical information to my bill, A means by which a third-party payer can verify that services billed were provided, and ·A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professions. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges: The right to review the notice prior to my signing this consent, and · The right to request restrictions as to how my health information may be used for disclosure to carry out treatment, payment, or health care operations. I understand that Dalton Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Dalton Dental reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dalton Dental change their notice, they will send a copy a copy of any revised notice to the address I've provided. I wish to have the following restrictions to the use or disclosure of my health information and/or I WISH TO ALLOW DISCLOSURE OF MY HEALTHCARE INFORMATION TO THE FOLLOWING PERSON(S): *

_____

_____

Patient Consent to Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations I understand that as part of my health care, Dalton Dental originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment. I understand that this information serves as: · A basis for planning my care and treatment, A means of communication among health professionals who contribute to my care, ·A source of information for applying my diagnosis and surgical information to my bill, · A means by which a third-party payer can verify that services billed were provided, and · A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professions. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: · The right to review the notice prior to my signing this consent, and · The right to request restrictions as to how my health information may be used for disclosure to carry out treatment, payment, or health care operations. I understand that Dalton Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dalton Dental reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dalton Dental change their notice, they will send a copy a copy of any revised notice to the address I've provided. I wish to have the following restrictions to the use or disclosure of my health information and/or I WISH TO ALLOW DISCLOSURE OF MY HEALTHCARE INFORMATION TO THE FOLLOWING PERSON(S): *

1. Your Information. 2. Your Rights. 3. Our Responsibilities. 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. Your Rights: You have the right to: get a copy of your paper or electronic medical record, correct your paper or electronic medical record., request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of this privacy notice, choose someone to act for you, file a complaint if you believe your privacy rights have been violated. Your Choices: You have some choices in the way that we use and share information as we: tell family and friends about your condition: provide disaster relief, include you in a hospital directory, market our services and sell your information, raise funds. Our Uses and Disclosures: We may use and share your information as we treat you, run our organization, bill for your services, help with public health and safety issues, do research, comply with the law, respond to organ and tissue donation requests, work with a medical examiner or funeral director, address workers' compensation, law enforcement, and other government requests, respond to lawsuits and legal actions.

More detailed information on each of these three areas follows. 1. Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, in a timely manner, without delay for legal review, usually within 30 days of your request. We may charge a reasonable cost-based fee for copying as authorized by the Florida Board of Dentistry but we will not condition copying upon payment of a fee for services rendered. Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. Get a list of those with whom we've shared information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information listed at the bottom of this Notice. You can file a complaint with the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint. 2. Your Choices For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: share information with your family, close friends, or others involved in your care. . share information in a disaster relief situation. include your information in a hospital directory.

If you are not able to tell us your preference, (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission and the written permission specifically lists the type of information being disclosed and prevents re-disclosure: Marketing purposes, Sale of your information . Most sharing of notes regarding psychotherapy, HIV and/or substance abuse. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again. 3. Our Uses and Disclosures How do we typically use or share your health information? We typically use or share your health information in the following ways: Treat you We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. Run our organization We can use and share your health information to run our practice, improve your care and contact you when necessary. Example: We use health information about you to manage your treatment and services. Bill for your services We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. Help with public health and safety issues We can share health information about you for certain situations, such as: . preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, preventing or reducing a serious threat to anyone's health or safety. Do research We can use or share your information for health research. Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner or funeral director when an individual dies. Address workers' compensation, law enforcement and other government requests We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law. for special government functions such as military, national security and presidential protective services Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena. Our Responsibilities. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. . We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

Other Information .We do not create or manage a hospital directory. We do not create or maintain psychotherapy and/or substance abuse information at this practice. We do not receive financial remuneration for marketing products or services in this practice. We do not sell patient information in this practice. We do not engage in fundraising at this practice. We do not engage in research studies at this practice. We may ask about HIV status because it is pertinent to your dental care but will make no further disclosure of such information without specific written consent from you or as otherwise required by law. We will never share any psychotherapy, HIV or substance abuse records without your written permission. A general authorization for release of records is not sufficient for us to release this type of information. We will ask you to sign a separate written consent form that specifically mentions this type of information before we release this type of information. If you direct us to release this type of information, we will instruct the recipient that further disclosure by the recipient requires your specific written consent.

Under Florida law, we are unable to submit claims to payers (your health plan) under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing a Consent form but, unless you pay in full out-of-pocket, we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it. Effective Date of this Notice is Sept. 23, 2013. QUESTIONS AND COMPLAINTS If you want more information about our privacy practices, have a question or have a concern about your personal information, please contact us as indicated below:

Our Privacy Official: Dr. Hilary Dalton, DALTON DENTAL Telephone: (813)872-8300
Fax: (813) 434-2218 Address: 4511 West Gandy Blvd, Tampa, FL 33611
Email: drdalton@daltondentaltampa.com

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT and I have been offered a copy of the DALTON DENTAL PRIVACY PRACTICES.

AS YOUR ELECTRONIC SIGNATURE, TYPE YOUR FULL NAME BELOW: *

_____

_____

_____

Response Date: ____/____/_____

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4511 West Gandy Blvd • Tampa, FL 33611
(813)872-8300

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____-____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Responisble party for all payments and/or payment guarantor? *

_____

_____

_____

Physician(s) and Phone #'s *

Do you have any existing illness(s)? * ◯ Yes ◯ No

If yes please explain:

Have you had any hospital visits in last 2yrs? * ◯ Yes ◯ No

If YES, please explain:

Do you bleed excessive after a cut? * ◯ Yes ◯ No

Do you use any tobacco products? * ◯ Yes ◯ No

If YES, what and how much? _____

If FEMALE are you pregnant? ◯ Yes ◯ No

If yes, what is your due date? _____

Have you ever been told that you require antibiotics prior to dental visits? * ◯ Yes ◯ No

Any Medical Conditions Past/Present: * _____

Have you ever taken the diet medication Fen-Phen? * ◯ Yes ◯ No

Have you ever taken a Bisphosphonate (osteoporosis) medication? * ◯ Yes ◯ No

DO YOU TAKE ASPIRIN DAILY? * ◯ Yes ◯ No

Please check conditions that apply

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Please list all allergies: *

_____

_____

Please list all Medications and Supplements: *

_____

_____

AUTHORIZATION and RELEASE: By signing below, I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my 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 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.

AS YOUR ELECTRONIC SIGNATURE, TYPE YOUR FULL NAME BELOW: *

_____

_____

_____

Response Date: ____/____/_____