Please complete all information – Thank You!

FIRST NAME:_____ LAST NAME:_____

Home #:( )_____- _____ Cell #:( )_____- _____Work #: ( )_____-_____

Address: _____

City: _____ State:_____ Zip Code: _____ DOB:_____

Occupation:_____ Sex: M F SS#:_____

Emergency Contact: _____ Relationship:_____ Phone: ( )_____- _____

How did you hear about us? _____

**** Email Address: _____

Dental History

Reason for today's visit: _____ Date of last dental visit: _____
Former Dentist: _____ Date of last dental x-rays**:** _____

Please check if you have/had:

Bad breath []
Blisters on lips or mouth **[]**
Burning sensation on tongue []
Chew on one side of mouth []
Cigarette, pipe, or cigar smoking []
Smokeless tobacco []
Dry Mouth []
Food collection between teeth []
Clench Teeth []
Grind teeth []
Growths or sore spots in mouth []
Gums swollen, tender/ bleeding []
Head,neck, or jaw pain or aches []
Lip or cheek biting []
Loose teeth or broken fillings []
Mouth Breathing []
Orthodontic Treatment []
Nitrous Oxide []
Periodontal Treatment []
Sensitivity to pressure []
How often do you floss? _____
How often do you brush? _____

Have you ever had allergic reactions to Novacaine, local or general anesthetics? If so, please explain:

_____
_____

Have you had trouble from previous dental care? If so, please explain: _____

_____
_____

Medical History

Physician's name/ Phone number: _____

Have you ever had a blood transfusion? Yes [] If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes [ ] If yes, give approx. dates: _____

Pregnant? Yes [ ] No [ ] Due date**: _____** Nursing? Yes [ ] No [ ] Birth control Pills? Yes[ ] No[ ]

PLEASE LIST CURRENT MEDICATIONS:

_____

Please check if you have/had

Allergies, hay fever, sinusitis []	Heart Problems []
Anemia []	Hepatitis? [] Type: _____
Arthritis, rheumatism []	Herpes []
Artifical heart valves []	High Blood Pressure []
Artificial joints []	HIV/AIDS []
Asthma []	Jaundice []
Bleeding abnormally with surgery []	Kidney Disease []
Blood disease, Clotting disorders []	Low blood pressure []
Cancer []	Pacemaker []
Chemical Dependency []	Radiation Treatments []
Chemotherapy []	Rheumatic Fever/ Scarlet Fever []
Circulatory Problems []	Sinus Trouble []
Cough, Persistent or bloody []	Stroke []
Diabetes []	Swelling of feet/ ankles []
Emphysema []	Thyroid Problems []
Epilepsy []	Tonsillitis []
Fainting []	Tuberculosis []
Glaucoma []	Tumors []
Headaches []	Weight loss, Unexplained []

Do you consume alcoholic beverages? Yes[ ] No [ ]

Are you allergic to latex? Yes [ ] No [ ] **Allergic to Penicillin, Aspirin or other drugs?If so explain**:

_____

_____

WELCOME TO SELECT DENTAL CARE

PATIENT'S NAME: _____

We welcome you to our practice and look forward to providing you with the best possible care. The information below will help to make the process smoother. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

1. All patients must complete our "patient information form" before seeing the dental professional.
    - Full payment is due at time of service.
    - We accept cash, checks, American express, Visa, MasterCard, Discovery and Care Credit.
2. Minor accompanied by an adult his/her parents or guardians are responsible for full payment at the time of service.
3. Select Dental Care provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that 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 the full amount of dental services that exceed the particular plan limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Select Dental Care staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Select Dental Care. However, if you are paid by the insurance company instead of Select 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.
4. Our goal at Select Dental Care is to provide quality dental care in a timely manner. In order to be respectful of the dental needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call **at least 48 hours in advance**, and/or calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely dental care. Failure to be present at the time of a scheduled appointment our policy is to charge for missed appointments. An administrative fee of $40.00 per each 30 minutes of missed appointment time will be assessed to the patient account. Please let us know if you have any questions or concerns.
5. Please advise the office BEFORE your next appointment if you change insurance companies, or we may have to reschedule you. (Some insurance companies require preauthorization prior to your visit).
6. If your insurance requires an authorization, it is your responsibility to ensure it is in our office before your appointment.
7. Advise the office immediately of any change in address, or telephone number.
8. This office does work by appointments; however, due to the nature of our practice, we sometimes experience delays. Please be patient as we give every patient the same careful attention.
9. Prescription refills and insurance questions may only be addressed during regular office hours.
10. The doctors do not discuss financial matters. If you need special arrangements to be made, please speak with our Office Manager.

WE LOOK FORWARD TO MAKING YOUR EXPERIENCE WITH US A PLEASANT ONE.

_____ _____ _____

Responsible party signature Relationship to patient Date

CONSENT FOR ELECTRONIC CHART IDENTIFICATION PHOTOGRAPH

Patient Name: _____ Date of Birth:_____

Select Dental Care ("SDC") will be using electronic medical records to maintain your health care information. The use of electronic medical records allows SDC to store a digital photograph and clinical pictures of a patient in such patient's electronic chart so that SDC doctors and staff may visually identify such patient while reviewing his or her chart.

SDC will only use the above-named patient's photograph and clinical pictures for treatment plan purposes and identification.

SDC is committed to maintaining the privacy and confidentiality of all patient health information in compliance with HIPPA.

The above-named patient may, at any time, withdraw this consent with written notice to SDC.

PLEASE CHECK ONE:

____ YES. The above-named patient agrees to have his or her digital photograph & clinical picture taken and stored in SDC's electronic medical records system. The above-named patient understands that by checking "yes" and signing this form, he/she is giving SDC permission to take a digital photograph and clinical picture of him/her to use in its electronic medical records system for identification purposes and treatments.

____ NO. The above-named patient does not wish to have his/her photograph taken and stored in SDC electronic medical records system for identification purpose.

By signing this consent, the undersigned acknowledges that he/she has read the contents of this document, fully understands it and agrees to be bound by it.

By: _____
(Print name of patient or patient's parent/legal guardian)

Signature: _____ Date: _____

Select Dental Care

HIPAA PATIENT CONSENT FORM

Our notice of privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change, if we change our notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

I give my permission to discuss my treatment and/or billing information with: _____

Relationship to patient: _____

This HIPAA consent was signed by: _____ _____
Signature of patient/guardian Printed name

Signature of practice representative: _____

FOR OFFICIAL USE ONLY

- Individual refuse to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)