# Pacific Hearts Dentistry

## Patient Information

Legal Name: LAST _____ FIRST _____ MIDDLE_____

Sex: □ Male □Female DOB: _____/_____/_____ Patient SS#: _____

Address: _____Apt.#: _____ City/State/Zip: _____

Cell Phone: _____ Alternate Phone: _____ Email: _____

Person providing information_____Relationship to patient_____

Are you a legal guardian: YES____ NO____ Who does the child reside with: Mom_____ Dad_____ Both____ Other:_____

Language Preferred: □ English □ Spanish □ other: _____ How did you hear about our office? _____

**Please initial here: _____**

## Responsible Party Information

Mother's Name or Legal Guardian: _____D.O.B ____/____/_____

Relation to Patient: _____ Employer_____ SS# _____-_____-_____

Cell Phone: _____ Alternate Phone: _____

Father's Name or Legal Guardian: _____D.O.B ____/____/_____

Relation to Patient: _____ Employer_____ SS# _____-_____-_____

Cell Phone: _____ Alternate Phone: _____

## Insurance Information

Primary Insurance: _____Eligibility/Benefits Phone #: _____

SS#/Policy #: _____Subscriber/Cardholder: _____DOB: ___/____/____

## Physician Information

Physician Name: _____Phone #: _____

Address: _____City:_____State/ Zip:_____

## Emergency Contact Information (Not in same household)

Name: _____

Relationship to Patient: _____

Contact Phone Number: _____

## Chief Complaint

Reason for today's visit: _____

## Dental History

When was your last dental visit/cleaning?

_____

How nervous is the patient about today's visit?

1 2 3 4 5 6 7 8 9 10

## Medical History

Are immunizations UP TO DATE? □**No** □**Yes**

Is the patient allergic to any MEDICATION or LATEX?

□**No** □**Yes**

If yes, please list: _____

Please list reactions: _____

If patient is taking any medications, please list below:

□**No** □**Yes**

| **Medications:** | **Dose:** | **Times Per Day:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Patient Medical History Please CIRCLE**

| | |
|---|---|
| Heart Conditions | High Blood Pressure |
| Rheumatic Fever | Kidney/Liver Disorder |
| Eye Disorders | Tumors/Growths/Ulcers |
| Prolonged Bleeding | Tuberculosis |
| Stroke | Anemia |
| Asthma | Epilepsy |
| Hepatitis | AIDS (HIV +) |
| Radiation Treatment | Venereal Disease |
| Arthritis | Currently Pregnant |
| Seasonal Allergies | Thyroid Condition |
| Autism | Scarlet Fever |
| Down Syndrome | Jaundice |
| Stomach/Intestinal Problems | Birth Control Pills |
| Heart Murmur | Artificial Heart Valve |
| Heart Pacemaker | Artificial Joints |
| Cold Sores/Fever Blisters | Glaucoma |
| Herpes | Fainting or Dizzy Spells |
| Psychiatric/Psychological Care | Bruise Easily |
| Allergic to Anesthetic | Breathing conditions |
| Blood transfusions | Stayed in ICU as Newborn |
| Major surgery | Complications during pregnancy |
| Premature | Chemotherapy |
| Cancer | Diabetes |

Other: _____

**Legal Guardian Signature: _____**

Doctor Signature: _____

Assistant Initial: _____ Date: _____

**Consent for Treatment**

Do you give permission for the following procedures be completed?

Dental Exam □**No** □**Yes** X-rays and images □**No** □**Yes** Dental cleaning □**No** □**Yes** Fluoride application □**No** □**Yes**

## **Cancellation Policy and Insurance Authorization Statement** (Sign & Date on bottom)

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please call with at least 24hour notice. This courtesy makes it possible to give your reserved time slot to another patient who needs an appointment. Considering Saturday's are especially popular appointment days, if you no show or cancel with less than 24 hours notice we have the right to refuse you be seen on another Saturday. By signing you agree that you have read & understand the cancellation policy. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I agree that I am fully responsible for any treatment costs which are denied or not covered by my insurance company. I also understand that it is my responsibility to give accurate insurance information to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

**Signature: _____ Date: _____**

## Notice of Privacy Act

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, treatment plan, health history and demographic data) may be used or disclosed by us in one or more of the following respects:

1.To other health care providers (i.e., referring office and/or doctor, oral surgeon, orthodontist, etc.) in connection with our dental treatment to your child.
2.To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.)
3.To certifying, licensing and accrediting bodies (i.e., the American Board of Dentist, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation.
4.Internally, to all staff members who have any role in your child's treatment; and or,
5.To other patients and third parties who may see or over hear incidental disclosures about your/ or your child's treatment, scheduling etc.:
6.To your family and close friends involved in your child's treatment;
7.We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you;
8.We may share your child's treatment plan and health history with other medical providers to help them in providing you care.

And other uses or disclosures of you, or your child's protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

1.Request restrictions on the use and disclosure of your child's protected health information;
2.Request confidential communication of your child's protected health information;
3. Inspect and obtain copies of your child's protected health information through asking us;
4. Amend or modify your child's protected health information in certain circumstances;
5. Receive an accounting of certain disclosures made by us of your protected health information; and,
6. You may, without risk of retaliation, file a complaint regarding a dental professional, by e-mailing the SBDE Enforcement Division at complaints@tsbde.state.tx.us or by phone @1.800.821.3205 (which must be filed within 180 days of the violation)

We have the following duties under the privacy rules:

1.By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
2.To abide by the terms of our Privacy Notice that is currently in effect;
3.To advise you of right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

1.Honor any request by you to restrict the use of disclosure of your protected health information:
2.Amend your protected health information if, for example, it is accurate and complete, or,
3.Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information on this Notice, please ask for our Privacy Person or direct your questions to this person at our office address. Thank you.

I, _____ acknowledge that I have read and understand this office's **Notice of Privacy Act, Cancellation Policy** and **Insurance Authorization Statement**

_____
Signature

_____
Date