Schofield Dental

PATIENT INFORMATION TODAY'S DATE ______________

Name: __________________________Preferred Name:____________________ Birth date:_____________________

Address: ____________________________ City: ______________________ State: ___________Zip: ____________

Home #: _____________________ Cell #: ________________________ Social Security #: _____________________

How do you prefer to communicate with our office for appointment confirmations? text email phone call

Email Address: ___________________ Patient Employer_____________ Work #: ___________________________

Spouse: __________________________________ Spouse's Phone #: ______________________________________

Emergency Contact: _______________________ Relationship: _____________________ Phone # _______________

Personal Reference: (friend or family member not living with you) ________________________Phone # _______________

If patient is a minor, who is legally responsible? Please list the name, complete address and phone numbers of the responsible party. ____

Whom may we thank for referring you? ____

DENTAL INSURANCE INFORMATION

Name of Primary insurance: _____________________________Name of policy holder: _______________________
Relationship to policy holder: ____________________________ Policy holder DOB: ___________________________
Policy holder's social security #__________________________ Subscriber ID # _____________________________
Policy holder's employer: ______________________________ Insurance policy group # _____________________

Name of Secondary insurance: ___________________________ Name of policy holder: _______________________
Relationship to policy holder: ____________________________ Policy holder DOB: ___________________________
Policy holder's social security #__________________________Subscriber ID # _____________________________
Policy holder's employer: _______________________________ Insurance policy group # _____________________

Authorization for treatment

The undersigned hereby authorize the doctors of Schofield Dental to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors of Schofield Dental to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient and further authorize and consent that the doctors of Schofield Dental choose and employ such assistants as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. We send out courtesy reminders for your appointment. Please let us know if you wish not to receive text or email communication.

PLEASE PROVIDE US WITH A COPY OF YOUR PHOTO ID & INSURANCE CARD. THANK YOU!

Signature of patient or legal guardian: ____ Date: ___________________
Signature of witness: ____Date: ___________________

DENTAL HISTORY

Patient Name_________________________ **Date of Birth** _________________________

Current Age_____________

	Yes	No
Are your teeth sensitive to:		
Heat	☐	☐
Cold	☐	☐
Sweets	☐	☐
Pressure	☐	☐
Does food catch between your teeth	☐	☐
Do your gums bleed when brushing	☐	☐
Have you noticed any gum swelling around teeth	☐	☐
Do you have an unpleasant taste/odor in your mouth	☐	☐
Problems of the Jaw:		
Clicking	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening/closing	☐	☐
Difficulty chewing	☐	☐
Do you avoid any part of the mouth while brushing	☐	☐
Have you had a reaction to a local anesthetic	☐	☐

Rate your teeth from 1-10 (1 being the worst, 10 being the best)_____

What would make it a 10?______________________________

	Yes	No
Are you concerned about the finances required to return your: teeth to excellent dental health	☐	☐
Do you use any tobacco products	☐	☐
Have you ever had any teeth removed	☐	☐

How long have they been missing_________________________

	Yes	No
Do you feel you will eventually wear artificial dentures	☐	☐
Do you have any dental fears	☐	☐

Do you have any present dental concerns___________________

____

Why did you leave your last dentist _______________________

____

When was your last dental exam______________________

	Yes	No
Do you have any general health problems	☐	☐

If so, please specify:________________________________

____

	Yes	No
Have you had surgery in past 5 years	☐	☐

If so, please specify:________________________________

____

	Yes	No
Are you currently under physician's care	☐	☐

Reason____

List Medications________________________________

____

	Yes	No
Have you/are you taking bisphosphonates?	☐	☐
To the best of your knowledge, are/have you ever been afflicted with:		
Heart Ailment____________________	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
Artificial joints	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis	☐	☐
HIV positive	☐	☐
Prolonged bleeding	☐	☐
Healing Complications	☐	☐
Allergies To any Drugs	☐	☐

If so, please specify:________________________________

If needed, which Pharmacy do you prefer?

____

	Yes	No
Are you pregnant?	☐	☐

Signature of Patient____________________________ **Date** ________________

Office Use Only

Date______________________________BP____________________________P______________________________

Notes____

Medications:

Allergies:

Signature of Dr or RDH_________________________________ PREMED (YES OR NO)________________________

Dear Valued Patient;

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

We have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

The most common reason why we use or disclose your health information is for treatment, payment, or specialty referrals. For treatment purposes we may disclose information for scheduling your appointments, treatment planning, prescribing prescriptions, referring you to a specialist, or getting your health information from another healthcare provider. For payment purposes we may disclose information when asking for information on your dental plans or other types of payment options, sending statements or claims, and collecting money (whether collection action through our office or an official collection agency). For specialty referral purposes we may disclose information when finding and informing an additional healthcare provider of needed treatment and concerns.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we generally will not ask you for special written permission.

In limited situations, the law allows or requires us to disclose your health information without your permission. Not all situations listed will apply in our office; however, we are still obligated to let you know all rights.

- When a state/federal law mandates certain health information be reported
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices from the Federal Food and Drug administration
- Disclosures to government authorities about victims of abuse or violence
- Disclosures for health oversight activities, such as the licensing of doctors, audits, or possible violations of health care laws
- Disclosures of judicial and administrative proceedings, such as in response to subpoenas or court orders
- Disclosures for law enforcement purposes, such as providing information about someone who is a victim of a crime, to provide information about a crime at our office or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death, to funeral directors, or organizations that handle organ/tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety
- Disclosures relating to worker's compensation programs

- Uses or disclosures for specialized government functions, such as protection of president or high ranking government officials, military personnel, or evaluation of health of members of the foreign services
- Incidental disclosures that are unavoidable by-products of permitted uses or disclosures
- Disclosures to "business associates" who perform healthcare operations for us and who commit to respect the privacy of your health information

APPOINTMENT CONFIRMATION: We may call or write you in regard to scheduling appointments. We may also call or write to notify you of further treatment or service available to you and your healthcare needs.

AUTHORIZATIONS: We may not make any other uses or disclosures of your health information without a written authorization from you. The content of the appropriate authorized form is determined by federal law. Both you and our office are authorized to initiate the authorization process. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we can not make the disclosure. If you do sign one, you may revoke it at any time unless we have already acted upon the request. When revoking a prior authorization we must receive written notice, which will then be kept in your file.

YOUR RIGHTS: The law gives you many rights regarding your health information

- You may inspect and obtain a copy of your health information that is used to make decisions about your care, including medical and billing records. We may charge you a reasonable cost-based fee for providing these records. By law there are a few limited situations in which we can refuse to permit access or copying.
- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency). We do not have to agree with this, but if we agree, we must honor the restrictions that you want. To ask for a restriction requires a written authorization to our office on your behalf.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. We will accommodate these requests if they are reasonable.
- Ask us to amend your health information. We require that you provide a reason to support the requested amendment, and we may deny your request if we did not create the record, if you do not have a right to access the record, or if we determine the record is accurate and complete.
- You have the right to request and receive an accounting of disclosures we have made of your health information for certain purposes after April 14, 2003. The right does not extend to disclosures made to you; for treatment, payment, or healthcare operations, to family members or to others involved in your healthcare or payment.
- To get additional paper copies of this Privacy Notice upon request.

CHANGE TO THIS NOTICE: We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If we do change our notice, we will post the new notice in our office and have copies available in our office.

COMPLAINTS: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with us by notifying our Privacy Officer, and we will not retaliate against you for filing a complaint.

I have been given the chance to read/obtain the privacy policy, and any concerns have been addressed.

Signature______________________________ Date______________

Relationship to Patient__________________

FINANCIAL INFORMATION AND AGREEMENT

We offer several financial options for your convenience. Knowing this ahead of time allows us both to arrange for completion of your treatment. After reviewing the following information, please let us know if you have any questions.

- **DENTAL INSURANCE**
  We want you to receive the full benefit of your insurance. We will verify coverage and file all claims on your behalf. You will be responsible for your **deductible** and **estimated** portion, these fees are **due the day services are provided.** Our estimate is based on limited information obtained from your insurance company. Regardless of what we might calculate as your dental benefits in dollars, we must stress the fact that you, the patient, are responsible for the entire fee. By choosing this option it can help reduce your immediate out-of-pocket expenditures.

- **CASH AND PERSONAL CHECKS**
  We accept cash and personal checks the day your treatment is provided.

- **VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS**

- **CARE CREDIT**
  For long term or extended payments, we offer a healthcare financing program, which allows you to make monthly payments extending over a 6 month to 60 month time period, **interest free options also available**.* On Approved Credit*

I understand the responsibility for payment of services provided in this office for myself or any dependents is mine, **due and payable in full at the time of service.** I also understand there are no in house financing options and I must use one of the options listed above. I do understand all delinquent accounts will be released to an outside collection agency and assessed a $50 charge. **A 24 hour notice is required for all cancelled appointments**. **Missed appointments without the required 24 hour notice are subject to a $59 charge.** Returned checks will be assessed a $25 charge. I hereby authorize payment of dental benefits directly to Schofield Dental.

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Signature required____ Date ____________________

Witness ____ Date ____________________