# welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient # _____

Soc. Sec. # _____

Date _____

## Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

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

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

**Over Please**

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ |
| If yes, please explain _____ | | |
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |
| If yes, what medication(s) are you taking? _____ | | |
| 4. Do you use tobacco? | ☐ | ☐ |
| 5. Do you use controlled substances? | ☐ | ☐ |
| 6. Are you wearing contact lenses? | ☐ | ☐ |

| 8. Are you allergic to or have you had any reactions to the following? | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. novocain) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |

| 9. Women Only: | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

7. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Other _____ | ☐ | ☐ |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking? | ☐ | ☐ |
| Pain (joint, ear, side of face)? | ☐ | ☐ |
| Difficulty in opening or closing? | ☐ | ☐ |
| Difficulty in chewing? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? | ☐ | ☐ |
| If yes, date of placement _____ | | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

# Authorization and Release

*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 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 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.*

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____

FORM 113846 ITEM 8101 N/05/04

Authorization for Signature on File:

Release of information/financial responsibility/authorization for payment:

I,_____and/or_____
Name of Patient Name of Insured

Hereby, authorize the office of Harvey I. Sherman, D.D.S., P.A. to affix my name to any and all claims or documents as related to any and all health benefits due me and/or my dependents through my employment with _____.

I authorize payment of dental benefits, otherwise, payable to me, directly to the practice of Harvey I. Sherman. I have received the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan. All accounts with a balance after 60 days will be charged interest at the rate of 1 ½ % per month or 18% per annum.

To the extent permitted under applicable law, I authorize release of any information related to all dental claims.

_____ _____
Signature of Guardian/Insured Signature of Witness

_____
Date

Privacy Practices for the office of Harvey I. Sherman, D.D.S., P.A.

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The office of Harvey I. Sherman has and will keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to provide you with and follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. Example: a review of your file by a specialist whom we may involve in your care, we may send a report on your progress to the doctor of referral.

We may use or disclose your health information for payment of your services. Example: we will file a claim to your insurance company for payment.

We may use or disclose your health information to our normal healthcare operations. Example: one of our staff will enter your information into the computer.

We may use your information to contact you. Example: we may send a newsletter or other information. We may also want to call and remind you about your appointments. If you are not home, we will leave this information on your answering machine or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of you health information when required by law.

If this practice is sold, your information will become the property of the new owner.

The practice will not use or disclose your health information without your prior written authorization, except as described above.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of all uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files upon request. You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information you need. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You may file a complaint with the Dept. of Health & Human Services, at #200 Independence Avenue, S.W., Room 509-F Washington D.C. 20201: contact Privacy Officer @ 123-456-7890. This notice is in effect as of April 14, 2003.

Acknowledgement: I have reviewed a copy of this Notice of Privacy Practices for the office of Harvey I. Sherman, D.D.S., P.A.

Print Name Sign Name Date