UPTOWN DENTISTRY

Name _____

Date ____/____/____

DENTAL & MEDICAL HISTORY **Birthdate** ____/____/____

Reason for today's visit _____ Date of last exam _____/_____/_____

How often do you brush? _____ Floss? _____ Mouthwash (type)? _____

Do you have any dental problems or history of an upsetting dental experience? ☐ Yes ☐ No

Describe _____

Have you ever had? ☐ Orthodontics ☐ Oral Surgery ☐ Periodontal Surgery

Please check any of the following conditions that apply to you:

☐ Bad breath
☐ Bleeding gums
☐ Clicking / popping jaw
☐ Food collection
☐ Sore facial muscles
☐ Difficulty opening / closing
☐ Loose teeth
☐ Broken tooth / filling
☐ Periodontal treatment
☐ Sores / growths in mouth
☐ Sensitivity to hot / cold / sweet
☐ Sensitivity when biting
☐ Dry mouth
☐ Grinding teeth / night guard
☐ Headaches or neck aches
☐ Other _____

Physician _____ Date of Last Visit _____/_____/_____

Current Medications and Reason For Taking _____

List all allergies _____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Please indicate which of the following you have had or currently have: (Check all that apply)

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial heart valves
☐ Asthma
☐ Back problems
☐ Blood thinners
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Clotting disorder
☐ Cold sores
☐ Diabetes Type I / II
☐ Epilepsy
☐ Glaucoma
☐ Headaches
☐ Heart murmur / problems
☐ Hemophilia
☐ Hepatitis
☐ High blood pressure
☐ HIV/AIDS
☐ Joint replacement
☐ Kidney trouble
☐ Pacemaker
☐ Rheumatic fever
☐ Sinus problems
☐ Steroid treatments
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Other/Describe above _____

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No

Have you had surgery or been hospitalized in the last 10 years? ☐ Yes ☐ No Describe: _____

Patient Signature _____ **Date** ____/____/____

UPTOWN DENTISTRY

Name _____

Date ____/____/____

PATIENT INFORMATION **Birthdate** ____/____/____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Phone: (Please circle preferred)

Home _____ Mobile _____ Work _____

May we contact you by email? ☐ Yes ☐ No Email Address _____

Emergency Contact _____ Phone _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name _____

Responsible Party (if patient is a minor) _____

Relationship to Patient _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

How did you hear about our office? _____

Previous dentist's name _____ Phone _____

Office address _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____/_____/_____ Subscriber ID # _____ Group # _____

Insurance Company _____ Insurance Company Phone # _____

Employer _____

Do you have additional insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____/_____/_____ Subscriber ID # _____ Group # _____

Insurance Company _____ Insurance Company Phone # _____

Employer _____

UPTOWN DENTISTRY

Name _____

TREATMENT & HIPAA CONSENT Date ____/____/____

TREATMENT CONSENT

Cancellation policy: Once an appointment is made, our time is reserved for your visit. 48 hours notice is appreciated for appointment cancellation. Appointment cancellation with less than 24 hours notice will be considered a missed appointment and subject to a $50 cancellation fee. Repeated missed and/or canceled appointments impact our ability to provide patient care and may result in dismissal from the practice.

I certify that I have read and understand the 'Patient Information' and 'Dental & Medical History' forms and that the information I provided is accurate. I understand that providing incorrect and/or inaccurate information may be hazardous to my health. I will inform the office of any health changes at my next appointment.

I agree to the use of anesthetics, sedatives and other medication as necessary to receive treatment. I understand that I can ask for a complete recital of any possible complications from anesthetics or dental procedures.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice.

I authorize Uptown Dentistry to take photographs of my face, jaws and teeth. I understand that these photographs will be used as a record of my care and for professional communications, and that these photos may be used for educational purposes, advertising, or professional publication without revealing my identity.

I understand that I am financially responsible for any outstanding balance for services provided to myself or my dependents that are not fully covered by insurance, and that I will be billed for any remaining balance.

Patient Signature / Date _____ ____/____/_____ Relationship to patient: _____

HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health 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 communicating among the many 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 actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing competence.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any changes to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization 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.

Patient Signature / Date _____ ____/____/_____ Relationship to patient: _____