### Prudential Dental

###  **Patient Information Today’s Date: \_\_\_\_\_\_\_\_\_\_**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

Home phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex ❒ Male ❒ Female

Age \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status ❒ Single ❒ Married ❒ Child

Patient Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (name & phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###  **Dental History**

Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last dental x-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check √ to indicate if you have any of the following:**

Bad breath ❒

Bleeding Gums ❒

Broken fillings ❒

Clicking/popping jaw❒

Dry mouth ❒

Fingernail biting ❒

Food collection in teeth❒

Foreign objects ❒

Grinding teeth ❒

Gums swollen /tender ❒

Jaw pain or tiredness ❒

Lip or cheek biting ❒

Loose teeth ❒

Mouth breathing ❒

Mouth pain ❒

Orthodontic treatment ❒

Pain around ear ❒

Periodontal treatment ❒

Sores in mouth ❒

Sensitivity to cold ❒

Sensitivity to heat ❒

Sensitivity to sweets ❒

Sensitivity when biting ❒

Please list any additional concerns that may have prompted your visit today.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

So we may better assist you, please indicate the service you are most interested in:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women only) Are you pregnant, nursing or taking birth control pills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check √ to indicate if you have any of the following:**

Anemia ❒

Arthritis, Rheumatism ❒

Artificial Heart Values ❒

Artificial Joints ❒

Asthma ❒

Back Problems ❒

Bleeding abnormally ❒

Blood Disease ❒

Cancer ❒

Chemical Dependency ❒

Chemotherapy ❒

Circulatory Problems ❒

Cortisone Treatments ❒

Cough, persistent ❒

Diabetes ❒

Emphysema ❒

Epilepsy ❒

Fainting or dizziness ❒

Glaucoma ❒

Headaches ❒

Heart Murmur ❒

Heart Problems ❒

Hepatitis ❒

Herpes ❒

High Blood Pressure ❒

HIV/ AIDS ❒

Jaw Pain ❒

Kidney Disease ❒

Liver Disease ❒

Low Blood Pressure ❒

Mitral Value Prolapse ❒

Nervous Problems ❒

Pacemaker ❒

Psychiatric Care ❒

Radiation Treatment ❒

Respiratory Disease ❒

Rheumatic Fever ❒

Scarlet Fever ❒

Shortness of Breath ❒

Sinus Trouble ❒

Skin Rash ❒

Special Diet ❒

Stroke ❒

Swollen Feet ❒

Swollen Neck Glands ❒

Thyroid Problems ❒

Tonsillitis ❒

Tuberculosis ❒

Tumor or growth ❒

Ulcer ❒

Venereal Disease ❒

Weight Loss ❒

#### Medications Allergies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above information is true to the best of my knowledge. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Guardian

Doctor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE AND AUTHORIZATION FOR TREATMENT**

1. I understand that there are no treatment guarantees.

2. I understand that my medical / dental situation can change, thus affecting the outcome.

3. I understand that all radiographs (x-rays), models, and any other diagnostic materials are the property of Prudential Dental Associates, Inc, and will be used by the Practice accordingly. This material may be used in a teaching environment.

4. As a patient I am entitled to a copy of my radiographs for a nominal fee upon written request.

5. I understand that there are health risks, although minimal, involved with any dental treatment.

6. I understand that even though I may have dental insurance, the ultimate responsibility for payment is mine. After a 30-day period, payment is due in full unless prior arrangements have been made.

7. If I miss a Hygiene appointment, or give less than a 2 business day notice for a cancellation or rescheduling, there will be a $75.00 fee assessed to my account.

8. If I miss a Dr.’s appointment, or give less than a 3 business day notice for a cancellation or rescheduling, there will be a $200.00 fee assessed to my account.

9. I authorize my dental insurance company to pay Prudential Dental Associates, Inc. directly.

10. I understand that if I do not pay my bill in a timely manner, late fees and finance charges will accrue.

 If the services of a collection agency are required, that fee will also, be my responsibility.

11. In the case of a divorce, it is the patient who makes the appointment or accompanies the child that is responsible for payment for dental services rendered.

My signature below constitutes my agreement to the above statements and authorizes fee, if applicable, to be assessed to my account.

Patient signature Parent / guardian for minor under age 18

**VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE**

**As a courtesy to our patients, our office will:**

Complete your insurance claim form and submit them to your carrier for you with proper documentation included.

* Accept direct payment from insurance carriers
* Use current ADA coding for correct reporting of procedures.
* If necessary, re-file your claim for a second time within a 60 day period.

Your responsibilities as a patient:

* Pay fees not covered by your plan at time of treatment.
* Provide our office with the necessary information concerning your insurance coverage to allow correct filing of claims.
* Understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
* Pay any account balance not paid by insurance in 30 days.

HIPAA Privacy Statement, Assignment and Release: In the event that I, and or my dependents have dental insurance coverage, it is agreed that any or all dental insurance benefits are to be assigned directly to Prudential Dental. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Prudential Dental Associates may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I read the Notice of Privacy and acknowledge that I have been fully informed of all my rights.

Patient or Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices Patient Acknowledgement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice’s legal duties with respect to my protected health information. The Notice includes:

* A statement that this practice is required by law to maintain the privacy of protected health information.
* A statement that this practice is required to abide by the terms of the notice currently in effect.
* Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care options.
* A description of each of the other purposes for which this practice is permitted or required to use to disclose protected health information without my written consent or authorization.
* A description of uses and disclosures that are prohibited or materially limited by law.
* A description of other uses and disclosures that will be made with my written authorization and that I may revoke such authorization.
* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
	+ The right to complain to this practice and to the Secretary of DHHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
	+ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
	+ The right to receive confidential communications of protected health information.
	+ The right to inspect and copy protected health information.
	+ The right to amend protected health information.
	+ The right to receive an accounting of disclosures of protected health information.
	+ The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_