

Dr. Steven Hernandez
Lifetime Dentistry

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your dental treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, social security numbers, demographic data) may be used in connection with your treatment, payment of your account or health care options (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice and I have reviewed this Privacy Consent.

Patient or Parent/Guardian's signature

Print name

Date

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 care 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 # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip _____
Email _____ Cell Phone _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If Student, Name of School/College/University: _____

Patient or Parent/Guardian's Employer _____ Wk. Phone _____

Business Address _____ City _____ State/Prov. _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Wk. 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 _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Wk. Phone _____ SS#/SIN _____

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 _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Wk. Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Wk. Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip _____

Insurance Company Address _____ City _____ State/Prov. _____ Zip _____

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 | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? If yes, please explain. _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic or do you have any reactions to the following? | | |
| | | | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Penicillin or any other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription drugs? If yes, what are you taking? _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revoti, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Other (please list) _____ | | |
| 8. Do you use a controlled substance? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 5 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | 13. Women only: | | |
| | | | a) Are you pregnant or think you may be? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | | Yes | No | | Yes | No |
|-----------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | STD | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prop | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/
Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____		Date of Last Exam _____			
	Yes	No	Yes	No	
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot /cold liquids/food?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet/sour liquid/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips/cheeks often?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult		
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever experienced any of the following problems in your jaw?			12. Have you ever had any prolonged		
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic		
Difficulty in opening/closing?	<input type="checkbox"/>	<input type="checkbox"/>	treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures of partials?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you received oral hygiene		
			16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>

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 answered accurately. 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 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 dependants.

Signature of Patient (or parent or guardian if minor)

Date

Doctor's Comments _____ _____ _____ _____ _____	
Signature	Date