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

## Welcome Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email\*: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharm. Telephone#: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Responsible Party DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Employer: \_\_\_\_\_

In the event of an emergency, who may we contact?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

<b>Primary Insurance Co.</b> _____
Insurance Co. Address: _____ City: _____
State: _____ Zip: _____ Group #: _____
Insured's Name: _____ Relation: _____
Insured's Date of Birth: _____ Insured's ID#: _____
Insured's Employer: _____
Employer's Address: _____
<b>Secondary Insurance Co. (if applicable)</b> _____
Insurance Address: _____
Group #: _____ Insured's Name: _____ Relation: _____
Insured's Date of Birth: ____/____/____ Insured's Employer: _____

Medical History

Do you have a personal physician? YES or NO

Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Are you currently under the care of your physician? YES or NO

If yes, explain:

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Are you currently taking any prescription/over the counter or supplemental drugs? YES or NO

Are you under treatment for osteoporosis or taking any osteoporosis medications? YES or NO

Please list all medications:

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Do you smoke or use tobacco in any other form? YES or NO

Females only

If you are women are you taking birth control? YES or NO

Are you pregnant? YES \_\_\_ NO \_\_\_ UNSURE \_\_\_ Week#: \_\_\_\_\_ Are you nursing? \_\_\_\_\_

Have you ever had any one the following diseases or medical problems?

(Please circle all that apply or write NONE)

Anemia	Epilepsy/ Seizures/ Fainting spell
Artificial Bones/ Joints/ Valves	Fever Blisters/ Herpes
Arthritis	Heart Attack/ Stroke
Asthma	Heart Murmur
Blood Transfusion	Heart surgery/ Pacemaker
Cancer/ Chemotherapy	Hemophilia/ abnormal bleeding
Diabetes	Hepatitis
Difficulty Breathing	High/Low Blood Pressure
Drug/ Alcohol Abuse	HIV+/ AIDS
Emphysema/ Glaucoma	Hospitalization for any reason
Mitral valve prolapsed	Kidney problems
Psychiatric problem	Shingles
Rheumatic/ scarlet fever	Sinus Problems
Severe/ frequent headaches	Ulcers/Colitis
Tuberculosis	VenerealDisease

Please list any serious medical conditions that you have ever had.

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Please list any surgeries you have ever had.

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Are you allergic to any of the following? (Please circle all that apply)

- |                         |                     |                   |
|-------------------------|---------------------|-------------------|
| Y N -Aspirin            | Y N -Erythromycin   | Y N -Penicillin   |
| Y N -Codeine            | Y N -Jewelry/Metals | Y N -Tetracycline |
| Y N -Dental Anesthetics | Y N -Latex          | Y N -Other        |

Please List any other drugs/materials that you are allergic to. \_\_\_\_\_

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Please explain to us why have you come to the dentist today? \_\_\_\_\_

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Are you currently in pain? \_\_\_\_\_ Do you require antibiotics before dental treatment? YES or NO

If so what for? \_\_\_\_\_

Please list your Pharmacies address and telephone number

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information to inform this office of any changes in my responsibility in inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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Signature

Date



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### 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 any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication 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 the competence of healthcare professionals

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 revised notice to the address I've 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 take action in reliance thereon.

Print Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



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### **Financial Responsibility & Assignment of Benefits**

*I understand that insurance billing is provided as a courtesy and that I am financially responsible to Commack Dental Design, PLLC for all charges arising from my treatment. It is my responsibility to notify Commack Dental Design, PLLC of any changes in my health care coverage. While Commack Dental Design, PLLC verifies my insurance eligibility, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies receive by me. I authorize direct payment from my health insurance plan to Commack Dental Design, PLLC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.*

#### *Cancellation Policy*

*We understand that circumstances may arise requiring you to cancel your scheduled appointment. Please try to give us a 24 hour cancellation notice.*

#### *Consent for Treatment and Release of Information*

- *I am aware of my diagnosis and wish to receive treatment from Commack Dental Design, PLLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me.*
- *I give permission to Commack Dental Design, PLLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.*
- *I authorize Commack Dental Design, PLLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.*
- *I certify that I have read this agreement and my signature indicates my understanding and consent.*

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