HARBOR EAST DENTAL

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Driver's License #: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Wk Phone: _____

Please check the appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Name of ☐Parent ☐Guardian ☐Spouse: _____ Phone: _____

Name of Emergency Contact: _____ Phone: _____

If college student: ☐Full time ☐Part time Name of School: _____ State: _____

Responsible Party (Only if different from above patient)

Name: _____ Date of Birth: _____

Relation: ☐Parent ☐Guardian ☐Spouse ☐Other:_____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Driver's License #: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Primary Dental Insurance Information

Name of Insured: _____ Date of Birth: _____

Relation to Insured: ☐Self ☐Parent ☐Spouse ☐Other Is this person a patient at our office? ☐Yes ☐No

Is this insurance plan through an employer? ☐Yes ☐No If yes, name of employer: _____

Ins. Company: _____ Ins. Phone: _____

ID #: _____ Group Name: _____ Group #: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Please let our staff know if you have additional insurance benefits.

Signature of Patient/Parent/Guardian: _____ Date: _____

Dental History

Former Dentist: _____ Date of last dental visit: _____

Please check if you have or had any of the following:

☐Bad Breath ☐Bleeding Gums ☐Smoking
☐Clicking or Popping of the Jaw ☐Food collection between teeth ☐Grinding of teeth
☐Gums swollen or tender ☐Loose teeth ☐Broken teeth or fillings
☐Orthodontic treatment ☐Hot or cold sensitivity ☐Sensitivity when chewing/biting
☐Sores or growths in the mouth ☐Wearing or chipping of teeth ☐Head or neck trauma
☐Snoring ☐Daytime sleepiness ☐Sleep apnea

How often do you brush your teeth? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

How often do you experience headaches? ☐Rarely ☐Occasional ☐Frequent ☐Severe

Wellness History

Please mark to indicate if you have any of the following:

☐ Aids ☐ Anemia ☐ Arthritis
☐ Artificial Heart Valve ☐ Artificial Joints ☐ Asthma
☐ Back Problems ☐ Bleeding Abnormality ☐ Blood Disease
☐ Cancer ☐ Chemical Dependency ☐ Chemotherapy
☐ Circulatory Problems ☐ Congenital Heart Lesions ☐ Cortisone Treatments
☐ Diabetes ☐ Emphysema ☐ Epilepsy
☐ Fainting or Dizziness ☐ Glaucoma ☐ Headaches
☐ Heart Murmur ☐ Hepatitis Type _____ ☐ High Blood Pressure
☐ High Cholesterol ☐ HIV Positive ☐ Jaundice
☐ Jaw Pain ☐ Kidney Disease ☐ Liver Disease
☐ Low Blood Pressure ☐ Mitral Valve Prolapse ☐ Nervous Problems
☐ Osteoporosis ☐ Pacemaker ☐ Psychiatric Care
☐ Radiation Treatment ☐ Respiratory Disease ☐ Rheumatic Fever
☐ Scarlet Fever ☐ Shortness of Breath ☐ Sinus Trouble
☐ Skin Rash ☐ Special Diet ☐ Stroke
☐ Swelling of Feet/Ankles ☐ Swollen Neck Glands ☐ Thyroid Problems
☐ Tonsillitis ☐ Tuberculosis ☐ Ulcer

Are you allergic, or have you reacted adversely to any of the following? (Please check all that apply):

☐Local anesthetics (Novocaine) ☐Penicillin or other antibiotics ☐Reaction to Metals
☐Sulfa Drugs ☐Aspirin, Acetaminophen, or Ibuprofen ☐Latex or Rubber
☐Barbiturates, sedatives, or sleeping pills

☐Other allergies: _____

Surgical History

Please note any operations or surgeries you've had: _____

Please list all current medications you are taking bellow:

Please check if you are currently taking either of the following: ☐Bisphosphonates ☐Blood thinners

Signature of Patient/Parent/Guardian: _____ Date: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Dental Insurance

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Photo Release

☐ I grant my permission to have any photos taken to be used for educational purposes only.

Cancelation Policy

At Harbor East Dental we strive to deliver excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an appointment cancelation policy that allows us to schedule appointments for all of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
We require that you contact our office 48 hours in advance in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, it will be considered a missed appointment. A fee of $95 dollars will be charged to you for missing scheduled treatment with our dentist. A $63 fee will be charged for a missed hygiene appointment. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and a cancellation fee will be charged.
If you have any questions or concerns regarding this policy please let our staff know and we will be glad to clarify any questions you may have.

Signature of Patient/Parent/Guardian: _____ Date: _____

HIPPA Compliance Patient Consent Form

Patient's Name: _____ Date of Birth: _____

Release of Information
Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your information with any members of your family or other persons authorized by you? ☐Yes ☐No

If yes, please name the members allowed:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Messages

May we phone, email, or send a text to you to confirm appointments? ☐Yes ☐No

If unable to reach me: ☐You may leave a detailed message.
☐Please leave a message asking me to return your call.

Signature of Patient/Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____