Smile Your Best Dental

Dodi R. Woolley, D.D.S. & Associates

Date_____

Patient Name

Last Name:_____ First:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Other #:_____

Social Security#:_____ Birthdate:_____ Age:____ Male:____ Female:____

Employer:_____ Address:_____ Phone:_____

E-Mail Address:_____

Who can we thank for referring you to our office?_____

Person Responsible For Account

Last Name:_____ First:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Other # :_____

Social Security #:_____ Birthdate:_____ Age:_____ Male:_____ Female:____

Employer:_____ Address:_____ Phone:_____

Single____**Married**____**Widowed**____**Divorced**____**Separated**____

Spouse Name_____ Birthdate_____

Relative or Friend whom we may contact in the event of an Emergency

Name:_____ **Phone:**_____

Dental Insurance Information(primary)

Insurance Co. Name_____

Insurance Address_____

Insurance Policy#_____

Insured's Name_____

Insured's Employer_____

SSN #_____ Local#_____

Secondary Insurance Information

Insurance Co. Name_____

Insurance Address_____

Insurance Policy#_____

Insured's Name_____

Insured's Employer_____

SSN #_____ Local _____

- **Insured Sign. Authorizing Ins. Payment to provider**_____

I have completed the health history information on the opposite side and reviewed all information. I understand that I am responsible for fees at the time of services rendered unless other financial agreements have been made in advance. If the account is not paid according to the agreement, I understand that I will be responsible for the cost of collection, including court costs and legal fees. I understand that where appropriate, credit bureau reports may be obtained.

- **Signature**_____ **Date**_____ **Reviewed by**_____ **Date**_____

Medical History

Do you have any CURRENT health problems or are you under a physician's care now? Yes_____ No_____
If yes, for what? _____

Physician's name_____ City_____ Phone_____

Are you currently taking any medications? Yes_____ NO_____ If yes, what for?_____

Please list all medications you are currently taking _____

_____

Are you Pregnant ? Yes_____ No_____ Have you had any operations/surgeries? Yes_____ NO_____

If yes please list ALL here along with the date/year of the procedure _____

_____

Please CHECK any of the following conditions you currently or previously have had

Heart Failure____	Artificial Joint (Hip/Knee)____	Anemia____	Cancer____	Smoke____
Heart Disease or Attack____	Asthma____	Blood Transfusion____	Chemotherapy____	Drug Addiction____
Angina Pectin____	Stroke____	Hemophilia____	Radiation Therapy____	Alcoholism____
High Blood Pressure____	Endocarditis____	A.D.S.____H.I.V.____	Tuberculosis____	Psychiatric Treatment____
Heart Murmur____	Heart Surgery____	Hepatitis A___B___C____	Diabetes____	Fainting/Dizzy____
Rheumatic Fever____	Mononucleosis____	Liver Disease____	Emphysema____	Nervousness____
Congenital Heart Lesions____	Sleep Apnea____	Sickle Cell Anemia____	Arthritis/Rheumatism____	Pain in Jaw Joint____
Mitrovalve Prolapse____	Tumors____	Allergies____	Bleeding Problems____	Speech Impediment____
Artificial Heart Valve____	Ulcers____	Sinus Trouble____	Bruise Easily____	Cold Sores____
Heart Pacemaker____	Kidney Trouble____	Epilepsy or Seizures____	Thyroid Disease____	Periodontal Disease____

Please CHECK any medications you are Allergic to or have had adverse reaction to

Penicillin____ Amoxicillin____ Erythromycin____ Clindamycin____ Sulfa____ Aspirin____ Codeine____ Valium____

Darvon____ Percodan____ Nitrous Oxide____ Local Anesthetic____ Augmentin___ Other_____

Do you have a LATEX allergy? Yes____ No____ Any nonmedical allergies? _____

Dental History

Reason for appointment today _____ Are you having pain? Yes___ No___ How Long? ____

When was your last dental –Exam_____ Cleaning_____ X-rays_____

Name of previous Dentist _____ City_____ Phone_____

Please rank the following in the order of which would KEEP YOU FROM having dental treatment

FEAR of Pain ____ COST of Treatment____ LACK of Concern____ MISSING work Time___ BAD experience____

- **Signature**_____ **Date**_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

_____
Signature of Privacy Officer