I consent to the diagnostic procedures and treatment mutually agreed upon by myself/ (for my child) and the dentist necessary for proper dental care. I consent to having the hygienist perform a cleaning, fluoride, and x-rays without the doctor present in the building, provided that the patient has been seen with the doctor within the past year. I consent to having students or other staff in the room for training purposes. I consent to the dentist's use and disclosure of my records or my child's records to carry out treatment to obtain payment and for those activities and health care operations that are related to treatment or payment.

Patient Signature____ Date __________________

Patient of Guardian's Signature ____

HIPPA Patient Acknowledgment of Receipt of Notice of Privacy Practices

Consent/Authorization/Release Form

My signature will also serve as a records release should I request they be sent to other Doctors/Practices.

________________________________ ____________________________ ____________

Please ***print the*** name of Patient ***Signature*** of Patient Date

____

Please print and sign name of Guardian/Legal Representative and Relationship if applicable

Please list any other parties who can have access to your health information

Name: ____________________________ Relationship: ___________________________

Name: ____________________________ Relationship: ___________________________

Name: ____________________________ Relationship: ___________________________

Patient Name: ____

Last, First, Middle Initial, (Preferred Name)

Date of Birth: __________ Gender: **M or F** Family Status: _______________

If Child, Parents Name: ____________ Responsible for this account: __________

Main Phone #: _______________ Cell Phone #: _______________

Address: ___________________ City: __________ State: ___ Zip Code: ________

Email Address: ______________________

Health Information

Please check all that pertain to you below:

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Amoxicillin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other: __________
- ☐ **Do you smoke or use tobacco?**

For Women Only:

- ☐ Are you taking birth control?
- ☐ Are you pregnant? ____weeks
- ☐ Are you Nursing?

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
  - Year______
- ☐ Artificial Heart Valve
  - Year_______
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Thinner
- ☐ Cancer/Chemotherapy
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emphysema

- ☐ Fainting Spells
- ☐ Fever Blisters/ Cold sores
- ☐ Frequent Headaches
- ☐ HIV/AIDS
- ☐ Heart Attack
  - Year_____
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve
- ☐ Pneumocystis

- ☐ Pre-Med B/4 Apt.
- ☐ Psychiatric Problems
- ☐ Respiratory Problems
- ☐ Seizures/Epilepsy
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Sleep Apnea/Snoring
- ☐ Stroke
- ☐ TMJ/TMD Problems
- ☐ Taking Herbs/Supplements
- ☐ Thyroid Problems
- ☐ Tonsils/Adenoids Removed
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____________

Please List ALL Medications:____

____

How did you hear about us?

___ Shopper ___ Facebook ___ Website ___Friend/Family/Neighbor