FIFTY-SEVEN 57 DENTAL PATIENT INFORMATION

Patient Full Name: _____ **Date:** _____

PATIENT INFORMATION (Authorized Contact Information)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security #: _____

Sex: M F Pronouns: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Our software allows you to use text and/or email for appointment reminders, appointment requests, and to give feedback.

(Check all that apply)

- ☐ Yes, I would like to receive **TEXT MESSAGES**
- ☐ Yes, I would like to receive **EMAILS**
- ☐ No, I am **NOT** interested in receiving texts or emails at this time.

RESPONSIBLE PARTY (Complete if patient is a minor or someone other than the patient is responsible for payment.)

First Name: _____ Last Name: _____ Middle Initial: _____

Responsible Party's Address (if different from patient address above): _____

City: _____ State: _____ Zip: _____

Best Phone Number to Reach Responsible Party: _____

Responsible Party's Birth Date: _____ Responsible Party's Social Security #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: _____ Policy Holder's Social Security #: _____

Policy Holder's Birth Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ Policy Holder's Social Security #: _____

Policy Holder's Birth Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

OTHER

How did you hear about us? _____

If referred, whom may we thank? _____

Please sign and date this form below. Your signature below indicates that the information on this is complete and accurate to the best of your knowledge.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian (if minor) Date

FIFTY-SEVEN 57 DENTAL HEALTH HISTORY

Patient Full Name: _____ **Date:** _____

HEALTH HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, Physician's Name: _____ Physician's Phone #: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
If yes, what for: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes, explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
If yes, list: _____

Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

WOMEN

Are you pregnant/trying to get pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

ALLERGIES

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

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Other: _____

HEALTH PROBLEMS

Do you currently or have you ever had any of the following? ***(Please check all that apply)***

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Join
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No
If yes, explain: _____

Are you required to take an antibiotic pre-medication for dental procedures due to an existing condition? ☐ Yes ☐ No
If yes, which medication do you usually take: _____

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. We charge what is the usual and customary for our area and will do our best to assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

Ultimately, however, **you are responsible for payment regardless of insurance companies' determinations of usual and customary rates**. We are happy to submit the claims to see that you receive the full benefits of your coverage; however, **we cannot guarantee any estimated coverage**. Because the insurance policy is an agreement between you and the insurance company, **all patients are ultimately responsible for all charges**.

Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment when possible. If there are any complications, we will assist you with any information you may need. We accept the following forms of payment: cash, check, and most major credit and debit cards. Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee to cover processing fees that are charged to our office. We are happy to discuss our charges and how they relate to your particular situation.

We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. Thank you for understanding our Financial Policy.

RESCHEDULING/ CHANGE IN SCHEDULE POLICY

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee of $100.00 will be charged to your credit card on file.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and agree to the Financial Policy and the Cancellation Policy of Fifty-Seven 57 Dental. I agree to a credit card on file that may be charged for violation of these policies or upon my approval for services rendered.

Signature of Patient or Responsible Party: _____ Date:_____

Credit Card Number_____ CDC code_____

Expiration Date_____

Fifty-Seven 57 Dental

JENNIFER N. REYES, DDS

Consent for Treatment
Authorization for Use and Release of Protected Health Information

CONSENT FOR GENERAL DENTAL TREATMENT

I consent to diagnostic procedures and treatment (including techniques) rendered by Fifty-Seven 57 Dental ("Practice") and to having clinical photographs taken that the dentist(s) in attendance deem necessary for my care. I agree to abide by all the rules and regulations of the Practice. I understand that prior to any diagnostic procedures or treatment (including techniques), or obtaining clinical photographs, I will be advised by the doctor or staff responsible for my care, and that I may ask questions concerning my treatment. I also understand that post-treatment complications including bleeding, pain, swelling, loss of teeth, and loss of implants may be a normal consequence of the treatment rendered. I understand that I am financially responsible for any treatment, regardless of estimates of insurance coverage discussed at time of treatment. I further understand that I may revoke this consent before such treatment is provided. I understand this consent will remain in force unless I revoke it in writing.

Initials: _____
Date: _____

PATIENT CONSENT FOR USE AND RELEASE OF PROTECTED HEALTH INFORMATION

I hereby consent to the Practice using and disclosing my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I authorize the Practice to release to government agencies, insurance carriers, or others who are financially liable for dental and medical care, all information needed to substantiate payment for such care, and allow others who are representatives thereof to examine and make copies of all records relating to my care and treatment. I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am aware that a revised Privacy Policy may be obtained by forwarding a written request to the Practice.

Initials: _____
Date: _____

PATIENT CONSENT TO ACCESS AND RELEASE INFORMATION TO AND FROM ELECTRONIC PRESCRIBING MEDICATION HISTORY DATABASE

I authorize the Practice to access all electronic prescribing medication history databases and to release my prescription medication history contained in and sent to any electronic prescribing medication history databases (including but not limited to information related to HIV/AIDS, alcohol or drug use problems/treatment, family planning, genetic diseases, mental health conditions, and sexually transmitted diseases) used by the Practice. I understand this history may not be comprehensive and includes medications which have been prescribed to me electronically. It is my responsibility to provide my dentist/care provider with a complete list of medications I am currently taking. I understand that the purpose of this consent is for the Practice to be able to access and exchange medication history information with authorized electronic prescribing services from other providers, pharmacies and/or third party pharmacy benefit programs/payors.

Initials: _____
Date: _____

PATIENT CONSENT TO CALLS/MAIL/EMAIL

I authorize the Practice to call my phone, cell phone or other designated location and leave a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and all matters incident to my treatment. I authorize the Practice to mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked Personal and Confidential. I authorize the Practice to email me any items or communications related to my care or that assist the Practice in carrying out TPO, such as reminder cards and patient statements. I certify the contact information provided by me below is correct and secure, and I assume responsibility for safe receipt of any and all communications. I agree to indemnify and hold the Practice harmless from and against any claim, action, demand, fee, fine or assessment by me or any third party resulting from my failure to provide accurate contact information or secure any communications directed to me by the Practice.

Initials: _____
Date: _____

By signing this form, I am authorizing the access, use or disclosure of my PHI as indicated above. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. The Practice is not required to agree to my requested restrictions, but if it does, it is bound by such agreement. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Phone Number(s) (Cell/Home/Work) Authorized Email Address

Optional: You may discuss my dental condition with my Parent/Child: _____
Name

****

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (please specify)