Burcham Dental Arts

Patient's Name _____

If Student Name, of School

_____

Date of Birth _____ **Male** ☐ **Female** ☐

If Child: Guardian or Parent

_____

Social Security _____

How do you wish to be addressed: ☐ **Single** ☐ **Married** ☐ **Widowed**

Address: _____**P.O. Box**_____

City_____ **State**_____ **Zip**_____

Home Phone _____**Cell**_____

Employer

_____**Phone**_____

May we call you at work? ☐***Yes*** ☐***No***

e-mail _____

Spouse Name _____ **Cell** _____

Employer _____

Whom May We thank for referring you? _____

Emergency Contact _____

Phone _____**Relation** _____

We may share your dental treatment and financial information with:

_____**Relation** _____

_____**Relation** _____

Patient's or Guardian's Signature

_____**Date** _____

Primary Insurance

Employee Name _____

Employer Name _____

ID# _____**Group #** _____
*** Insurance Card and Picture ID required**

Secondary Insurance

Employee Name _____

Employer Name _____

ID# _____**Group #** _____
*** Insurance Card and Picture ID required**

_____

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, or obtain payment and for those activities and health care operations that are related to treatment or payment.

My Consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature

_____**Date**_____

Burcham Dental Arts
Notice of Privacy Practices

This notice describes how your dental/medical information may be used and disclosed along with how you may get access to your information. Please review it carefully.

The United States Department of Health and Human Services, effective August 9, 2002, issued comprehensive federal regulation providing for protection of private medical information with which our office must comply. The regulation is designed to protect your identifiable health information.

The HIPAA privacy rule states that after April 14, 2003, health providers must provide patients with a written Notice of Privacy Practices and make a good faith attempt to obtain a written acknowledgement of such. In addition, a Notice of Privacy Practices must be displayed prominently and available for patients to take home.

The Health Insurance Portability and Accountability Act of 1996 requires that health providers keep your medical and dental information private.

The following describes how information about you may be used.

TREATMENT

Your health information may be provided to our staff members, other dentists, your physicians, and /or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointment reminders, recommendations of treatment alternatives, information about other health services and /or other office services.

PAYMENT

Your health information as required may be provided to allow payment of services and participation in quality assurance, disease management, training, licensing, and certification programs.

LEGAL REQUIREMENTS

Your health information will be disclosed when required by law.

THREAT to HEALTH and SAFETY

If we reasonably suspect abuse or neglect, we may disclose your health information to the appropriate governmental authorities.

NATIONAL SECURITY

We may disclose military personnel health information to the Armed Forces / authorized federal official when required. Health information for inmates in custody of law enforcement may be provided to correctional institutes.

PATIENT AUTHORIZATIONS

You may request that your health information be disclosed to appointed persons if necessary to assist with your treatment and/or payment of services. This authorization should be in writing and can be revoked, in writing, at any time. Without your written authorization, disclosures about your health information are limited to those listed in this Notice. Per 164.522(a) of HIPAA, upon our judgment we may disclose your information to these persons in the event of an emergency, or to allow them to pick-up prescriptions, medical supplies, records or x-rays for you. Your information may also be disclosed in notifying the appointed persons of your condition.

PATIENT RIGHTS

You have the right to see your information and receive copies of your records under most circumstances.

If you believe that changes should be made to your health information or you request additional restrictions on the disclosure of your information, you must summit a written request. Even with your written request we have the right to refuse it under certain circumstances.

QUESTIONS & COMPLAINTS

If you have a complaint or need more information about our privacy practices please let us know. We completely support your right to privacy**.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I give my permission to be contacted about my dental treatment / appointment by mail via reminder postcard, e-mail, and phone. I give my permission to for messages to be left concerning my appointments / treatment via answering machine or other means. I also give permission to call my work to leave messages concerning my appointments.

If you do not wish to be contacted by any of the above means, please specify:

_____

Signature of Patient or Guardian

_____ **Date** _____

Witness_____ **Date** _____

Title of Witness _____

AGE 13 & OVER

Name _____

Medical Doctor _____**Phone**_____

Pharmacy _____ **Phone**_____

Medical Conditions

CHECK ALL THAT APPLY

☐	ABNORMAL BLEEDING	☐	HEART MURMUR or MVP
☐	ALCOHOL ABUSE	☐	HEART SURGERY
☐	ALLERGIES	☐	HEMOPHILIA
☐	ANEMIA	☐	HEPATITIS A
☐	ANGINA (Chest Pain)	☐	HEPATITIS B
☐	ARTHRITIS	☐	HEPATITIS C
☐	ARTIFICAL JOINTS	☐	HIGH BLOOD PRESSURE
☐	ARTIFICIAL HEART VALVE	☐	HIV+ AIDS
☐	ASTHMA	☐	KIDNEY PROBLEMS
☐	BLOOD TRANSFUSION	☐	LIVER DISEASE
☐	CANCER-CHEMOTHERAPHY	☐	LOW BLOOD PRESSURE
☐	COLITIS	☐	PACE MAKER
☐	CONGENITAL HEART DEFECT	☐	PNEUMOCYSTIS
☐	COSMETIC SURGERY	☐	PSYCHIATRIC PROBLEMS
☐	DIABETES	☐	RADIATION THERAPY
☐	DIFFICULTY BREATHING	☐	RHEUMATIC FEVER
☐	DRUG ABUSE	☐	SEIZURES
☐	EMPHYSEMA	☐	SHINGLES
☐	EPILEPSY	☐	SICKLE CELL DISEASE
☐	FAINTING SPELLS	☐	SINUS PROBLEMS
☐	FEVER BLISTERS	☐	STROKE
☐	FREQUENT HEADACHES	☐	THYROID PROBLEMS
☐	GLAUCOMA	☐	TUBERCULOSIS
☐	HAY FEVER	☐	ULCERS
☐	HEART ATTACK	☐	VENEREAL DISEASE
☐		☐	YELLOW JAUNDICE

ALLERGIES

☐ **Dental Anesthetics** ☐ **Codeine** ☐ **Metals** ☐ **Jewelry**

☐ **Erythromycin** ☐ **Penicillin** ☐ **Tetracycline** ☐ **Aspirin** ☐ **Latex**

☐ **Other**_____

Do you use tobacco or smoke? …….. YES NO

IF Female: Are you taking Birth Control Pills? ……. YES NO
Are you pregnant? ……... YES NO
If yes, how many weeks? _____
Are you nursing? …….. YES NO

MEDICATIONS (please list all currently taking)

_____

_____

Are you taking or have you taken in the past ten years and cancer or osteoporosis (bone treatment) drugs (examples: Aredia, Zometa, Fosamax. Ect.) _____ If yes please list: _____

_____

Do you have any disease, condition, or medical problem not covered above? _____ If yes, please describe: _____

I understand I am responsible for notifying this office of any and all health or medication changes. I also state the above information is accurate to the best of my knowledge

Signature of Patient or Guardian

_____ **Date** _____

PERIODIC MEDICAL UPDATES

I have reviewed the above information and have made the necessary changes

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

CHILDREN 12 & UNDER

Patient Name _____

Date of Birth _____

Parent or Guardian _____

Medical Doctor _____**Phone**_____

Pharmacy _____ **Phone**_____

Dental History – *circle the appropriate answer*

1. **Is this your child's first visit to the dentist? ..... YES NO**

2. **If not, how long since the last visit to the dentist?** _____

3. **Were any x-rays taken at your child previous visit? ..... YES NO**

4. **Have there been any injuries to teeth, such as falls, blows, chips, etc? ..... YES NO**

If so describe _____

_____

5. **Has your child had any problem with dental treatment in the past? ..... YES NO**

6. **Has your child ever received local anesthetic? ..... YES NO**

7. **Does your child think there is anything wrong with his/her teeth? ..... YES NO**

MEDICAL HISTORY

1. **Is your child under care of physician? ..... YES NO**

If yes, since when and why? _____

_____

2. **Has your child ever had surgery? ..... YES NO**

3. **Does your child have a heart murmur? ..... YES NO**

4. **Does your child experience severe or prolonged bleeding? ..... YES NO**

5. **Does your child have AIDS or has he/she tested HIV positive? ..... YES NO**

6. **Has your child tested positive for hepatitis? ..... YES NO**

7. **Is your child subject to nervous disorders? ..... YES NO**

FAINTING? SEIZURES? DIZZINESS? BEHAVIORAL/LEARINING PROBLEMS?

8. **Does your child have any disease, condition, or medical problem not covered on this form?**

YES NO If yes, please describe: _____

_____

9. **Has your child ever had a reaction to Nitrous Oxide Gas? ..... YES NO**

If yes, explain _____

If no, may we give your child Nitrous Oxide Gas during dental treatment? ..... YES NO

ALLERGIES

☐ **Dental Anesthetics** ☐ **Codeine** ☐ **Metals** ☐ **Jewelry**

☐ **Erythromycin** ☐ **Penicillin** ☐ **Tetracycline** ☐ **Aspirin** ☐ **Latex**

☐ **Other**_____

_____

MEDICATIONS (please list all currently taking)

_____

_____

_____

I understand I am responsible for notifying this office of any and all health or medication changes. I also state the above information is accurate to the best of my knowledge. By signing below I knowledge that I am the legal parent/guardian and I am responsible for all charges for the above named patient.

Signature of Parent or Guardian

_____ **Date** _____

PERIODIC MEDICAL UPDATES

I have reviewed the above information and have made the necessary changes

_____ **Date** _____

_____ **Date** _____