



PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date _____ SSN _____
 If minor, parents names _____ Home phone _____ Work phone _____
 Mailing address _____ City _____ State _____ Zip _____
 Employer _____ Occupation _____
 Spouse's name _____ Spouse's employer _____ Unmarried
 Whom may we thank for referring you to our office? _____ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance
 Dental Insurance Co. _____ Group number _____
 Covered by spouse's insurance? yes no
 Spouse's dental insurance company _____ Group number _____
 Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

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

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? yes no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant
 Expected delivery date: _____
- Taking hormones or contraceptives

Name of your Physician: _____ Physician Phone # _____

Do you have any disease, condition, or problem not listed above? _____

Signature of patient (or parent) _____ Date _____



Carlisle Family Dental

Patient Acknowledgement of Policies

Financial Policy

Thank you for choosing us as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best care in the most pleasant environment possible. In order to make financial arrangements for your treatment, we offer several flexible payment options. We accept cash, checks, all major credit cards, as well as extended payment plans upon credit approval. For unaccompanied minors, we ask that you make financial arrangements prior to the day of their appointment.

Dental Insurance

We are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and your portion of the cost of the treatment, which is due at the date of service. Since this is an estimate only, you may have an additional balance due, or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage.

Summary of Notice of Privacy Practices

(Our Privacy Practices comply with Omnibus 2013)

Carlisle Family Dental keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect, and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice. Our Privacy Practices comply with Omnibus 2013, and are updated effective 09/23/2013.

* You May Refuse to Sign This Acknowledgment*

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

Print Name: _____ Signature _____ Date _____

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) _____
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Consent for Treatment

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I permit the recommended diagnostic procedures, to be completed.

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of treatment.

I consent to the injection and administration of local anesthetics. I understand that there is an element of risk with the injection of any injectable agent. These risks include, but are not limited to: adverse drug reactions, allergic reactions, cardiac arrest (heart stops beating), tachycardia (very fast heart beat), swelling, bruising, pain, transient or permanent nerve damage (numb lip, etc.), asthmatic reactions (difficulty breathing), needle tract infection and other unspecified injuries.

I wish to proceed with treatment

Patients Name

Patients Signature

Date

Parent or Guardian

Parent or Guardian Signature

Date

I refused to proceed with treatment

Patient's Name

Patient's Signature

Date

Parent or Guardian

Parent or Guardian Signature

Date