CONFIDENTIAL PATIENT INFORMATION

PATIENT'S NAME_____

DATE OF BIRTH_____ SS#_____

MAILING ADDRESS_____ CITY, STATE, ZIP_____

EMAIL_____CELL #_____HOME #_____

___MINOR ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

EMPLOYER_____WORK PHONE_____

WORK ADDRESS_____

SPOUSE/PARENT/GUARDIAN NAME_____

EMERGENCY CONTACT_____PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

ADDRESS_____PHONE#_____

RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

NAME OF PERSON INSURED_____ RELATIONSHIP TO PATIENT_____

DATE OF BIRTH_____SS#_____

NAME OF EMPLOYER_____

INSURANCE COMPANY NAME AND ADDRESS_____

INSURANCE COMPANY PHONE_____GROUP #_____ID#_____

DO YOU HAVE A SECONDARY INSURANCE? _____YES _____NO

SECONDARY INSURANCE INFORMATION

NAME OF PERSON INSURED_____ RELATIONSHIP TO PATIENT_____

DATE OF BIRTH_____SS#_____

NAME OF EMPLOYER_____

INSURANCE COMPANY NAME AND ADDRESS_____

INSURANCE COMPANY PHONE_____GROUP #_____ID#_____

_____

PATIENT SIGNATURE OR PARENT/GUARDIAN DATE

PATIENT DENTAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT?_____WHAT WAS DONE?_____

PREVIOUS DENTIST NAME AND LOCATION_____

DATE AND LOCATION OF LAST COMPLETE SET OF DENTAL XRAYS_____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD GET CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT	☐	☐
IF YES, WHEN_____		
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
DO YOU HAVE SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
EVER HAD ANY NECK OR JAW INJURIES?	☐	☐
IF YES, PLEASE EXPLAIN_____		
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
EVER HAD A DIFFICULT EXTRACTION	☐	☐
DO YOU WEAR DENTURES, PARTIALS, OR A BITE APPLIANCE	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?_____
_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE ABOVE QUESTIONS HAVE BEEN ANSWERED ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE DR. ALLEN TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND THE RECORDS, OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES RENDERED. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

PATIENT MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A VITAL PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE AND MEDICATIONS THAT YOU MAY BE TAKING, HAVE AN IMPORTANT RELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY.

PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER_____DATE OF LAST PHYSICAL_____
ARE YOU IN GOOD HEALTH? YES NO ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO
HAVE THERE BEEN ANY CHANGES TO YOUR HEALTH WITHIN THE LAST YEAR? YES NO
IF YES, PLEASE EXPLAIN_____
DO YOU CURRENTLY TAKE ANY MEDICATION, PRESCRIPTION OR OVER THE COUNTER? YES NO
PLEASE PROVIDE A LIST OF ALL MEDICATIONS AND WHAT THEY ARE USED FOR. YOU MAY USE THE BACK OF THIS FORM IF YOU NEED MORE ROOM OR PROVIDE A COPY TO THE PROVIDER._____
HAVE YOU EVER HAD ANY SURGERIES OR SERIOUS ILLNESS? IF YES, PLEASE EXPLAIN.
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

	YES	NO		YES	NO
ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:					
ANTIBIOTICS?	☐	☐	HIVES OR SKIN RASH	☐	☐
IF YES, PLEASE SPECIFY_____			FAINTING OR DIZZINESS	☐	☐
LOCAL ANESTHESIA?	☐	☐	DIABETES	☐	☐
NARCOTICS, BARBITUATES, OR SLEEPING PILLS?	☐	☐	HYPOGLYCEMIA	☐	☐
ASPIRIN?	☐	☐	AIDS OR HIV INFECTION	☐	☐
IODINE?	☐	☐	THYROID PROBLEMS	☐	☐
METALS?	☐	☐	ARTHRITIS	☐	☐
LATEX/RUBBER?	☐	☐	JOINT IMPLANT OR REPLACEMENT	☐	☐
OTHER?	☐	☐	STOMACH TROUBLE	☐	☐
DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:			KIDNEY TROUBLE	☐	☐
RHEUMATIC OR SCARLET FEVER	☐	☐	TUBERCULOSIS	☐	☐
HEART DEFECT/MURMUR, MITRAL VALVE PROLAPSE	☐	☐	PERSISTENT COUGH	☐	☐
HEART DISEASE, HEART ATTACK, ANGINA	☐	☐	COUGH PRODUCING BLOOD	☐	☐
HEART SURGERY, PACEMAKER, STENTS	☐	☐	CANCER OR LEUKEMIA	☐	☐
CHEST PAIN	☐	☐	CHEMOTHERAPY OR RADIATION	☐	☐
SHORTNESS OF BREATH	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐
HIGH OR LOW BLOOD PRESSURE	☐	☐	EPILEPSY OR SEIZURES	☐	☐
JAUNDICE, LIVER DISEASE, OR HEPATITIS	☐	☐	ANEMIA	☐	☐
STROKE	☐	☐	MENTAL HEALTH CARE	☐	☐
SEASONAL ALLERGIES	☐	☐	NERVOUS DISORDERS	☐	☐
ASTHMA	☐	☐	TUMORS	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐	CHEMICAL DEPENDENCY	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐	EATING DISORDERS	☐	☐

ANY OTHER PROBLEM, DISEASE, OR CONDITION NOT LISTED THAT WE SHOULD KNOW ABOUT: _____
_____

WOMEN ONLY: ARE YOU PREGNANT,THINK YOU MAY BE PREGNANT, OR NURSING?_____

MICHAEL T ALLEN, DDS, LLC

419 NORTH CHURCH ST
THOMASTON, GA 30286

PATIENT CONSENT FORM

PATIENT NAME_____DATE OF BIRTH_____

I understand that that the patient's health information is private and confidential. I understand that the office of Dr. Michael T Allen, DDS, LLC works very hard to protect the patient's privacy and preserves the confidentiality of the patient's personal health information.

I understand that Dr. Michael T Allen, DDS, LLC may use the patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations. In general, there will be no other disclosures of this information unless I permit it. I understand that sometimes the law may require release of this information without my permission. These situations are rare.

Under the terms of this consent, I can ask Dr. Michael T Allen, DDS, LLC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Dr. Michael T Allen, DDS, LLC does not have to agree with my request. If Dr. Michael T Allen, DDS, LLC does not agree to my request, I understand that they will follow the agreed terms.

I may cancel in writing at any time by doing one of the following:

-Signing and dating a form that Dr. Michael T Allen, DDS, LLC can provide me called Revocation of Consent for Use and Disclosure of Health Care Information or
-Writing, signing, dating a letter to Dr. Michael T Allen, DDS, LLC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's health information for treatment, payment, and health care operations.

If I revoke this consent, Dr. Michael T Allen, DDS, LLC does not have to provide any further health care services to the patient.

My signature indicates that I have been given the chance to review a current copy of Dr. Michael T Allen, DDS, LLC "Notice of Privacy Practices". My signature means that I agree to allow Dr. Michael T Allen, DDS, LLC to use and disclose the patient's personal health information to carry out treatment, payment, and health operations.

_____

PATIENT OR LEGAL GUARDIAN DATE

MICHAEL T ALLEN, DDS, LLC

419 NORTH CHURCH ST
THOMASTON, GA 30286

NOTICE OF PRIVACY PRACTICES
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PATIENT NAME_____DATE OF BIRTH_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment both directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:_____Date:_____

Printed Name:_____

Relationship to Patient:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so.

Date_____ Initials_____ Reason_____