Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Dr. Simon Melcher & Dr. Emily Rodriguez

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please 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)

_____

_____

_____

Health History

Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	SARS	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
			Heart Stent/Shunt	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bone Density Medications (i.e. Fosamax, Boniva, Actonel, Reclast)	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			Herpes/cold sore	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tobacco/Smokeless Tobacco	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
			Pacemaker	☐ Yes	☐ No	Sexually Transmitted Diseases	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care /Depression	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ No Known Allergies

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other _____

_____

DENTAL HISTORY

1. What is your major dental concern? _____

_____

2. Date of your last visit to a dentist? _____
3. Reason for your last visit or series of visits? _____
4. Date you last had dental x-rays taken? _____
5. Have you always had your teeth cleaned at least once a year? ..... Yes No Don't Know
6. Do you use dental floss once a day? ..... Yes No Don't Know
7. Is there fluoride in your drinking water? ..... Yes No Don't Know
8. Do you brush your teeth at least once a day? ..... Yes No Don't Know
9. Do you use toothpaste that contains fluoride? ..... Yes No Don't Know
10. Do you need to have antibiotic premedication before dental treatment? ..... Yes No Don't Know
11. Have you ever fainted during a dental visit? ..... Yes No Don't Know

    If yes, explain: _____
12. Have you experienced an unusual reaction to dental medication or anesthetic? ..... Yes No Don't Know
13 Have you experienced prolonged bleeding following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
14. Have you had any other complications following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
15. Have you had any injury to teeth, jaws or face? ..... Yes No Don't Know

    If yes, explain: _____
16. Are you happy with the appearance of your teeth? ..... Yes No Don't Know
17. Do your gums bleed when you brush your teeth or when you eat? ..... Yes No Don't Know
18. Does food or dental floss catch between your teeth? ..... Yes No Don't Know
19. Are some of your teeth becoming loose? ..... Yes No Don't Know
20. Are there spaces between your teeth now where there were none before? ..... Yes No Don't Know
21. Are any of your teeth sensitive to hot, cold or pressure? ..... Yes No Don't Know
22. Do any of your teeth ache? ..... Yes No Don't Know
23. Do you experience pain or clicking in your jaw joints? ..... Yes No Don't Know
24. Are there any sores or growths in your mouth? ..... Yes No Don't Know
25. Are you worried about receiving dental treatment? ..... Yes No Don't Know
26. Do you have any other dental concerns or complaints? ..... Yes No Don't Know

    If yes, explain: _____

    _____

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

PERSON COMPLETING THIS FORM: Signature _____ Date _____

If other than patient, indicate relationship: _____

Simon P. Melcher, DDS
Emily M. Rodriguez, DDS

FINANCIAL POLICY

Thank you for choosing us as your dental provider. We are committed to your treatment being successful. This financial policy will prove helpful in determining your responsibilities for treatment.

INSURANCE AND USUAL AND CUSTOMARY FEES

Our office understands the value of insurance benefits to our patients. **We will file your insurance as a courtesy**. Please understand dental insurance is a contract between the patient and the insurance carrier. All fees including deductible and co-pay amounts are due when treatment is performed. **You are responsible for payment regardless of any insurance determination. There are no guarantees of payment from any insurance company and payment for dental services is the patient's responsibility.**

DELIQUENT ACCOUNTS

We reserve and will exercise the right to report any account 90 days delinquent to a collection agency. All expenses incurred as a result will be the patient's responsibility.

MISSED APPOINTMENTS

Appointments are valuable blocks of time. When an appointment is broken or cancelled with short notice (less than 24 hours), we are often prevented from filling that time and helping other patients. **We will charge a $75 non-refundable fee for all appointments broken or cancelled with less than 24 hours notice (unless special circumstances prevail).**
**** The first broken appointment will be a courtesy notice – the second broken appointment shall be charged. ****

I have read and understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsibly Party **Date**

INFORMED CONSENT FOR LOCAL ANESTHESIA

This consent form is designed to make you aware of the risks involved with local anesthetics. The risks include, but are not limited to:

A) There are risks of anesthesia that may affect your body, such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions. Any or all of these may require additional medical management or hospitalization.

B) Restricted mouth opening during recovery sometimes related to muscle soreness at the site of the injection requiring physical therapy.

C) Local anesthetic may cause prolonged numbness in some patients that may result in injury from biting or chewing an area such lip cheek or tongue that has received the local anesthetic.

D) Injury to nerves that can result in pain, numbness, tingling or other sensory disturbances to the chin, lip, cheek, gums or tongue. This may persist for several weeks, months and may rarely be permanent.

E) Local anesthesia is administered with a very small fine needle. In very rare instances these needles may break off and be lodged in soft tissue.

Please ask the dentist if you have any questions regarding this consent form. Do not initial or sign any blank if you have not had your questions answered.

I hereby acknowledge that I have read this document and I have discussed all questions or concerned that I might have regarding local anesthesia.

Patient Signature_____Date_____

Witness_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____

Date_____Initials_____ Date_____Initials_____