



DR. BOB MALEY
F A M I L Y D E N T I S T R Y

We'll keep you smiling!

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms
Mailing Address: (Street, City, State, Zip) _____
Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____
In Case of Emergency Contact
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above
Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms
Mailing Address: (Street, City, State, Zip) _____
Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____
Insurance Company: _____ ID Number: _____ Group Number: _____
☐ Additional Insurance
Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms
Mailing Address: (Street, City, State, Zip) _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No
Social Security Number: _____ Drivers License Number: _____
Occupation: _____ Employer: _____ Employer Phone: _____
Employer Address: (Street, City, State, Zip) _____
Insurance Company: _____ ID Number: _____ Group Number: _____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____



Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

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

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

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Please list any medications, pills, or drugs you are taking: _____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____



DR. BOB MALEY
F A M I L Y D E N T I S T R Y

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Please initial each

_____ I hereby authorize the Dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.

_____ I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for service and that I am financially responsible for payment in full of all accounts on which discounts do not apply.

_____ I understand that it is my responsibility to be aware of my insurance benefit package through my employer, and provide the dental staff with accurate and up to date insurance information in order to process my claim. I understand that not providing this information could result in non payment by my insurance carrier, and that I am financially responsible for all services rendered against my account and/or the account/s of my dependent children.

_____ I agree to pay finance charges of 1.5% per month that will be added to unpaid balances of 60 days or more.

I have read the above statements and indicated by initialing each that I understand my responsibilities.

Signature (parent signature if child)

Date

***Form must be updated yearly**

1. _____
signature / date

4. _____
signature / date

2. _____
signature / date

5. _____
signature / date

3. _____
signature / date

6. _____
signature / date

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0._____ for each page, \$_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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)

