Linn Family Dental

PATIENT INFORMATION/HEALTH HISTORY

PATIENT

Name _____ Preferred_____ Date_____ Social Security#_____-____-_____
First Last MI

Address _____ City_____ State ____ Zip_____

Date of Birth ___/___/___ Cell Phone_____ Work_____ Home _____

❑ M ❑ F ❑ Married ❑ Single ❑ Minor ❑ Other Email_____

Employer _____ Referred by_____

Emergency Contact Name:_____ Phone:_____ Relationship _____

Reason for today's visit_____

HEALTH HISTORY

Are you allergic to any medication? ❑ Y ❑ N *(Please list):* _____

Are you allergic to latex? ❑ Y ❑ N

Please list ALL medications you are currently taking _____

_____

_____

Preferred Pharmacy _____

Are you taking any medications for bone density? *(Please list)* _____

Are you taking any blood thinners? ❑ Y ❑ N

Please check any of the following that apply:

_____AIDS/HIV
_____ALCOHOL/DRUG ABUSE
_____ANEMIA
_____ANXIETY/DEPRESSION
_____ARTIFICIAL JOINTS-Year: _____
_____ASTHMA
_____AUTISM
_____AUTOIMMUNE DISEASE
_____BLOOD DISEASE
_____CANCER-Type: _____
❑ Chemo ❑ Radiation

_____CONGENITAL HEART DEFECT
_____DIABETES
_____DIZZINESS
_____EMPHYSEMA
_____EPILEPSY
_____EXCESSIVE BLEEDING
_____FAINTING
_____GLAUCOMA
_____HEAD INJURY
_____HEART DISEASE/HEART ATTACK
_____HEART MURMUR

_____HEPATITIS
_____HIGH BLOOD PRESSURE
_____HIGH CHOLESTEROL
_____KIDNEY DISEASE
_____LATEX ALLERGIES
_____LIVER DISEASE
_____LUPUS
_____LOW BLOOD PRESSURE
_____MITRAL VALVE PROLAPSE
_____OSTEOPOROSIS
_____PACEMAKER

_____RESPIRATORY PROBLEMS
_____RHEUMATIC FEVER
_____SEIZURES
_____SEXUALLY TRANSMITTED DISEASES
_____STROKE
_____THYROID PROBLEMS
_____TMJ/TMD PROBLEMS
_____TOBACCO HABITS
Type: _____
How Long:_____
_____TUBERCULOSIS (TB)

For Female Patients: Are you pregnant? ❑ Y ❑ N Week #_____ Are you nursing? ❑ Y ❑ N

Please list any conditions not listed above _____

Name of Primary Physician_____ Phone #_____

Have you been admitted to a hospital or needed emergency care during the past 2 years? ❑ Y ❑ N If **Yes** please explain _____

_____

DENTAL HISTORY

Have you had any complications following dental treatment in the past 2 years ❑Y ❑N If **Yes** please explain _____

_____

Are you currently in dental pain? ..... ❑Y ❑N
Are you aware of any broken teeth or fillings? ..... ❑Y ❑N
Have you had head neck or jaw injuries or pain? .... ❑Y ❑N
Have you ever had periodontal disease? ..... ❑Y ❑N
Do you or any members of your family wear dentures? . ❑Y ❑N

Do you require antibiotics before treatment? ..... ❑Y ❑N
Do you have sores or lumps in or near your mouth?.. ❑Y ❑N
Do your gums ever bleed while brushing or flossing? ❑Y ❑N
Do you have mobility in your teeth?..... ❑Y ❑N
Would you like whiter teeth?..... ❑Y ❑N

SPOUSE OR RESPONSIBLE PARTY *(IF OTHER THAN YOURSELF)*

Name _____ Relationship _____
Last *First* *MI*

Date of Birth____/____/____

Phone _____ Social Security# ____-____-____

Billing Address _____

DENTAL INSURANCE INFORMATION

Insured _____ SS #____-____-____

Insurance Company _____ Phone _____

Is Insured a Patient? ❑Y ❑N Insured's DOB____/____/____ Relationship to the Insured ❑Self ❑Spouse ❑Child ❑Other_

ID# _____ Group# _____

Insured's Employer _____

CONSENT FOR PAYMENT

In consideration for the professional services rendered to me during treatment I agree to pay on the date of service. If insurance will be filed for these procedures our office will assist in most insurance claims. I certify that I am covered by the dental insurance listed above. Insurance assignments shall be paid directly to Linn Family Dental. I understand that I am responsible for payment of services rendered and am also responsible for any co-payment and deductible amounts not covered by insurance. I hereby authorize Linn Family Dental to release all information necessary to secure the payment of benefits and I authorize the use of this signature on all my insurance submissions. I am aware that any pre-authorized procedures or quotes given by our office and/or the insurance company are estimates ONLY. I understand that treatment plan fee estimates may only be extended for a period of 6 months from the date of examination. I grant my permission to the staff at Linn Family Dental to contact me by phone, email or text using the information provided on this form. This consent shall be considered in effect until rescinded or revoked.

_____ _____
(Printed name – Patient, Parent or Guardian) (Date)

_____ _____
(Signature) (Date)

CONSENT FOR SERVICES

I give consent for **myself / my child** (please circle) to receive dental treatment deemed necessary by the providers at Linn Family Dental. I certify that I have read and understand the information on this form and answered all questions to the best of my ability. I also realize that it is my responsibility to inform this office of any changes in my medical status. I understand providing incorrect information may be dangerous to my health. This consent shall be considered in effect until rescinded or revoked.

_____ _____
(Printed name – Patient, Parent or Guardian) (Date)

_____ _____
(Signature) (Date)

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**

This consent form allows Linn Family Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Linn Family Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Linn Family Dental.

____ Initial I hereby authorize Linn Family Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and 2) Information related to billing and payment.

____ Initial I hereby authorize that Linn Family Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Email __ Home Phone __ Office Phone __ Cell Phone

____ Initial I hereby authorize that Linn Family Dental may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

____ Initial I hereby authorize that Linn Family Dental may disclose my personal health information to the person who I have listed as my emergency contact.

____ Initial I hereby authorize that Linn Family Dental may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

Furthermore, my (or my child's) personal health information **may NOT** be disclosed to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent if I do so in writing, but that Linn Family Dental services may still use information to complete any actions that it began prior to my revoking consent, and which rely on my protected health information. I understand that Linn Family Dental may refuse service if I revoke this consent.
I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Linn Family Dental is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____