Joe Pinney
family Dentistry

Date: _____

PATIENT INFORMATION (CONFIDENTIAL)

Patient Name: _____ Date of Birth:_____

SS#:_____Home Phone: _____ Cell: _____

Address: _____City: _____State: _____ Zip: _____

Driver's License #: _____ Occupation: _____

Employer:_____ Work Phone: _____

E-Mail: _____

Please circle Response: Child Single Married Widowed Male Female

Parent/Guardian _____ Spouse: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY

Person Responsible for Account: _____ Date of Birth: _____

Relationship to Patient: _____

Whom may we thank for referring you _ Internet _ Website _ Patient_____

INSURANCE INFORMATION

Name of policy holder: _____ Policy holder date of birth: _____

Employer: _____ SS# for Policy Holder: _____

Insurance Company: _____ Phone number:_____

Member or Subscriber ID#_____Group#_____

Claims mailing Address: _____

HEALTH HISTORY

Name _____ Today's Date_____

Date of Birth_____ Age _____ Height_____ Weight_____

Date of last health care exam _____ What was this exam for _____

Are you currently receiving care? Yes No If yes, nature of care? _____

Have you ever had any serious illness, surgery or been hospitalized? Yes No

If yes, Reason _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following medical conditions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Pressure High or Low	No	Yes	Stroke	No	Yes
Diabetes	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Heart Disease, Angina, Heart attack, Heart surgery	No	Yes	Fainting or Dizzy Spells	No	Yes
Heart Stent or Pacemaker	No	Yes	Kidney Disease	No	Yes
Heart Valve or Heart Transplant	No	Yes	Renal Dialysis	No	Yes
HIV Infection/AIDS or ARC	No	Yes	Glaucoma	*No*	*Yes*
Women: Are you pregnant	No	Yes	Cancer or Tumor	*No*	*Yes*
Are you trying to become pregnant	No	Yes	Radiation or chemotherapy	*No*	*Yes*
Asthma or other lung diseases	No	Yes	Psychiatric or mental health therapy	*No*	*Yes*
Emphysema or COPD other respiratory	No	Yes	Joint Replacement? When?	*No*	*Yes*
Sleep Apnea	No	Yes	Previous bacterial endocarditis	*No*	*Yes*
Liver disease, Jaundice, or Cirrhosis	No	Yes	Allergies or Sinus Trouble	*No*	*Yes*
Hepatitis –any form	No	Yes	Slow healing mouth Sores	*No*	*Yes*
Arthritis, rheumatism or other	No	Yes	Unintentional weight loss or gain	*No*	*Yes*
Blood disorders or abnormal bleeding	No	Yes	Previous Biopsies	*No*	*Yes*
Congenital Heart Disease	No	Yes	Venereal disease	*No*	*Yes*
Thyroid problems	No	Yes	Other conditions	*No*	*Yes*
Epilepsy or other neurological disease	No	Yes	Recurrent illnesses	*No*	*Yes*
Is there any other problem we should now about?	No	Yes	Please list:		

Are you taking any of these medications?

Pre-Medication before Dental Treatment	No	Yes	Tagamet or Prilosec	No	Yes
Antacids	No	Yes	Cardizem or calan, isoptin	No	Yes
St Johns Wort or Kava-Kava	No	Yes	Serzone	No	Yes
Dilantin or Tegretol	No	Yes	Diflucan or Sporonox	No	Yes
Barbiturates	No	Yes	Biaxin	No	Yes
Have you been treated with Bisphosphonate Drugs? Fosamax, Aredia, Zometa, Actonel, Boniva If so, When did the treatment begin? When did it end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss				No	Yes

Please List any medications you are currently taking

1._____ 2._____ 3._____
4._____ 5._____ 6._____
7._____ 8._____ 9._____

Please list any dietary or herbal supplements you are taking and for what purpose:

1._____ 2._____ 3._____
4._____ 5._____ 6._____

Women: Are you Pregnant? No Yes

Are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? No Yes

Have you ever received a diagnosis of: (Please Circle) High blood pressure Low Blood Pressure
What is your normal blood Pressure: _____ Today's blood pressure_____

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine No Yes
b. Penicillin or other antibiotics No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium, Hydrocodone, Oxycodone No Yes
e. Latex or Metals No Yes
f. Other (Please specify)_____

Chief Dental Complaint:_____

Have you had any trouble associated with any previous dental work? _____
Are you wearing any removable dental appliances No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? No Yes
If yes, circle type: Smoke Chew How much per day? _____ For how long?_____

Do you want to quit using tobacco? No Yes

Do you consume alcohol? No Yes
If yes, approximately how many alcoholic beverages a week? _____

Do you use mood altering drugs other than those previously listed? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health and medications.

_____ _____ _____
Patient (Print Name) Patient Signature Date

_____ _____ _____
Doctor Doctor Signature Date

FINANCIAL POLICY

*****You are fully responsible for your Account*****

Please initial as you read each of the following:

1. Dental Insurance- We are happy to file the necessary forms to your insurance company so that you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage because your insurance policy is an agreement between you and your insurance company. You are ultimately responsible for all charges. Estimated payments must be paid at the time of your appointment.
   (____)

2. Patient will be responsible for missed appointment fee of $25 if not cancelled 24 hours prior to appointment. We reserve the right to not reschedule you after a third cancellation.
   (___)

3. Any accounts not paid in full within 90 days will be placed with a collection agency and listed with the credit bureau. You agree to pay all collection and attorney fees if suit were instituted to collect money owed by you. This includes fees of up to 40% of the unpaid balance that may be assessed by our dental office to pursue this matter.
   (____)

4. You grant permission to our office to telephone you at home or at your workplace to discuss matters related to your account.
   (___)

5. You authorize assignment of payment of all dental and/or surgical benefits to which you and other family members are entitled to Dr. Joe Pinney. This includes private dental insurance and other group health plan benefits otherwise payable to undersigned.
   (___)

I certify that I have read this form and that I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Responsible Party Signature Date Relationship to patient

Joe Pinney
family Dentistry

PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability act of 1996. I understand that signing this consent form, I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (e.g. my Insurance company)
- The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your notice of privacy practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, and you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed Patient Name _____

Date _____

Signature_____