Insurance Authorization

I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Patient Signature (or Patient's Representative):_____

HIPAA Acknowledgement

I have been informed that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed, I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Signature (or Patient's Representative):_____

Consent for Services and Financial Responsibility

As a condition of treatment for this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid with cash at the time services are performed unless other arrangements have been made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written arrangements have been made. I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of the dental examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within 10 days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

Patient Signature (or Patient's Representative):_____

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

Y / N Heart Disease
Y / N Heart Murmur
Y / N MitralValve Prolapse
Y / N High Blood Pressure
Y / N Prolonged Bleeding Disorder
Y / N Anemia
Y / N Asthma
Y / N Ulcers
Y / N Epilepsy/Seizure Disorder
Y / N Implants/Artificial Joints
Y / N Liver Disease
Y / N Hepatitis Type _____
Y / N Diabetes Type _____
Y / N Herpes
Y / N Tumor or Malignancy
Y / N Cancer
Y / N Radiation/Chemotherapy
Y / N HIV/AIDS
Y / N Sexually Transmitted Disease
Y / N Kidney Disease
Y / N Emotional/Nervous Disorder
Y / N History of Drug Abuse
Y / N Taken Fen-Phen or Redux
Y / N Glaucoma

Y / N Stroke, Lou Gerig's Disease, Myasthenia Gravis, Tardive Dyskinesia (please circle)
Y / N I usually take an antibiotic before dental treatment.
Y / N I smoke or use tobacco. If yes, how much per day ? _____ How many years?_____
Y / N Any condition not previously listed_____
Y / N Any Surgeries or Hospitalizations _____
_____

Y / N Allergies to medications?
Y / N Sulfa Drugs
Y / N Codeine
Y / N Local Anesthetics (Novocaine)
Y / N Penicillin
Y / N Latex
Y / N Other? _____

OFFICE USE ONLY:

Women:
Y / N I am currently taking birth control medication Y / N Are you or could you be pregnant or are you nursing?

Daily medications:
Medicine: _____Taken for? _____
Medicine: _____Taken for? _____
Medicine: _____Taken for? _____
Medicine: _____Taken for? _____

Physician's Name: _____Phone: (_____)_____ - _____

Do you often feel tired, fatigued, or sleepy during daytime? Yes / No
Has anyone observed you stop breathing during sleep? Yes / No
Have you been previously diagnosed with sleep apnea? Yes / No
If yes, were you put on CPAP Therapy for treatment? Yes / No
Are you still using your CPAP every night? Yes / No

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing)

Sitting and reading_____	0	1	2	3
Watching television_____	0	1	2	3
Sitting in a public place_____	0	1	2	3
As a passenger in a car for one hour_____	0	1	2	3
Driving a car stopped for a few minutes in traffic_____	0	1	2	3
Sitting and talking to someone_____	0	1	2	3
Sitting down quietly after lunch without alcohol_____	0	1	2	3
Lying down to rest in the afternoon_____	0	1	2	3

OFFICE USE ONLY:

Patient Signature (or Patient's Representative):

_____ Date: ____ / ____ / ____

Doctor Signature:

_____ Date: ____ / ____ / ____