Welcome

Patient Information (CONFIDENTIAL)

Date: _____

First Name: _____ Middle Int: _____ Last Name: _____

Prefer to be called: _____ Referred by _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext _____ Cell: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Birth Date: _____ Social Security #: _____ Drivers License #: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Student Status: ◯ Full Time ◯ Part Time

Spouse Name: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Work Phone: _____ Cellular: _____

In the event of an emergency contact: _____ ***Relationship:*** _____

Home Phone: _____ ***Work Phone:*** _____ ***Cellular:*** _____

Insurance Information

Name of Insured: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Birth Date: _____ Insured Social Security #: _____

Name of Employer: _____ Work Phone: _____ Ext: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Birth Date: _____ Insured Social Security #: _____

Name of Employer: _____ Work Phone: _____ Ext: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Opelika Dental Arts, P.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please list: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

Notice of Privacy Practices

Opelika Dental Arts P.C.

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of the Notice of Private Practices.

Patient Name_____

Relationship to Patient_____

Signature_____Date_____

Opelika Dental Arts request that each patient sign this consent form which allows us to share protected health information with family members such as their spouse, parents or others to call and request information. By signing this form, you consent to our use and disclosure of protected information about you for treatment and payment. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Opelika Dental Arts P.C. to release protected information to the following individuals:

1._____Relation to Patient_____Date_____

2._____Relation to Patient_____Date_____

3._____Relation to Patient_____Date_____

☐ Authorize

☐ I do not Authorize except in regards to the Notice of Privacy Practices

OPELIKA DENTAL ARTS, PC
1957 1ST AVENUE
OPELIKA, AL 36801
(334) 745-3135

- **PAYMENT IN FULL IS EXPECTED WHEN SERVICES ARE RENDERED**. If you have dental insurance, your estimated portion is due in full when treatment is performed. On occasion, your insurance company may consider our fees higher than their usual and customary range. You are responsible for any difference between our fees and what the insurance company allows.

- **WE DO NOT EXTEND CREDIT**, but in the event there is an unpaid balance, there will be a service charge of $2.00 or 2% per month, which ever is greater on past due accounts.

- **WE REQUIRE 24 HOURS NOTICE FOR CANCELLING AN APPOINTMENT.** We understand that situations occur that may conflict with scheduled appointments. In the event of multiple appointments being cancelled or missed without sufficent notification, there will be a $31.00 charge added to your account. * We reserve the right to reschedule your appointment if you are more than 10 minutes late for your appointment and we are not able to work you in.

- **ASSIGNMENT OF BENEFITS.** I authorize the release of any necessary information about treatment, payment or health care operations, in order to provide healthcare that is in my best interest. I hereby authorize the group insurance benefit payment directly to this office otherwise payable to me.

- **EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:** You agree, in order for us to service your account or to collect monies you may owe, Opelika Dental Arts, P.C., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

- **AGREEMENT TO PAY:** I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.3%), attorney fees and/or court costs, if such be necessary.

- I certify that I have read the above and agree to abide by these items

_____

Signature (Patient or Guardian if Minor) Date