Creating and Caring for Beautiful Smiles

Patient Information Today's date:____________________

Name:____ Preferred name ____________________

SS#______________________________

Birthdate:_______________Age:_________ Male [ ] Female [ ] DL#______________________

Home Address____

City________________________State____________Zip___________

Phone # ______________________________

Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ]

Employer____Work Ph #___________________

Work Address____

Occupation____

Email ____

How did you hear about us? ____

Who can we thank for referring you? ___________________________________

Spouse Information

Name:____ Phone # ___________________________

Email ____

In case of an emergency, who should we contact?

Name:_______________________________________

Relationship:__________________________________

Phone #_______________________________________

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 7990 Orange

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (“CLIA”) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual’s dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Signature :____ Date _________________________

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 60 days old will be subject to a monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney’s fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50 broken appointment fee. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature :____ Date ___________________________

EMAIL CONSENT FORM

This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Quinn Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Quinn Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Quinn Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Quinn Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Quinn Dental.

[___] I consent and accept the risk in receiving information via email

[___] I do not want to receive information via email

TEXT MESSAGING CONSENT FORM

This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Quinn Dental offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Quinn Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Quinn Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Quinn Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Quinn Dental.

[___] I consent and accept the risk in receiving information via text messaging

[___] I do not want to receive information via text messaging

CONSENT FOR PHOTOGRAPHY

I, ________________________________ authorize Quinn Dental to take and/or reproduce photographs/video of my teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

I acknowledge I have read, and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of me for educational and marketing purposes. I release Quinn Dental from any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Signature :____ Date ___________________________

INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ]No

Would you like to learn more about our in-house membership plan? [ ] Yes [ ]No

Primary Dental Insurance

Patient relationship to insurance holder: [ ] self [ ] spouse [ ] child [ ] other

Policy holder name:____ SS# ______________________

Policy holder date of birth____________________________________

Policy holder address ____

City _____________________ State ______________________ Zip ___________________________

Policy holder phone number ____________________________________

Policy holder employer ____

Dental Insurance Co.________________________________

ID # ____ Group #________________________

Phone number on the back of your insurance card ____

Address on the back of your insurance card ____

City _____________________ State ______________________ Zip ____________________________

Secondary Dental Insurance

Patient relationship to insurance holder: [ ] self [ ] spouse [ ] child [ ] other

Policy holder name:____ SS# ______________________

Policy holder date of birth____________________________________

Policy holder address ____

City _____________________ State ______________________ Zip ___________________________

Policy holder phone number ____________________________________

Policy holder employer ____

Dental Insurance Co.________________________________

ID # ____ Group #________________________

Phone number on the back of your insurance card ____

Address on the back of your insurance card ____

City _____________________ State ______________________ Zip ____________________________

DENTAL HISTORY

Who was your previous Dentist and how long were you a patient there? ________________________________

Date of your last dental exam ____________________ Date of your last cleaning ______________________________

Do you have any immediate concerns you'd like us to address? ____

What do you value most in your dental visits? ____

Is there anything you prefer during your visits to make you more comfortable during your time with us?

____

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment? __________________________

[ ] Yes [ ] No Are you concerned about the appearance of your teeth?

[ ] Yes [ ] No Are you interested in improving your smile?

[ ] Yes [ ] No Have you had any cavities within the past 2 years?

[ ] Yes [ ] No Are any teeth currently sensitive to biting, sweets, hot, or cold?

[ ] Yes [ ] No Do you avoid or have difficulty chewing or biting heavily any hard foods?

[ ] Yes [ ] No Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?

[ ] Yes [ ] No Do you clench your teeth in the daytime?

[ ] Yes [ ] No Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?

[ ] Yes [ ] No Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?

[ ] Yes [ ] No Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?

[ ] Yes [ ] No Have you ever noticed a consistently unpleasant taste or odor in your mouth?

[ ] Yes [ ] No Do your gums bleed when brushing or flossing?

[ ] Yes [ ] No Is brushing or flossing typically painful?

[ ] Yes [ ] No Have you ever experienced or been told you have gum recession?

[ ] Yes [ ] No Have you ever been treated for or been told you have gum disease?

[ ] Yes [ ] No Have you had any teeth removed for braces or otherwise?

[ ] Yes [ ] No Do you know of any missing teeth or teeth that have never developed?

[ ] Yes [ ] No Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"

[ ] Yes [ ] No Are your teeth becoming more crowded, overlapped, or "crooked?"

[ ] Yes [ ] No Are your teeth developing spaces?

[ ] Yes [ ] No Do you frequently get food caught between any teeth?

[ ] Yes [ ] No Have you noticed your teeth becoming shorter, thinner, or flatter over the years?

[ ] Yes [ ] No Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)

[ ] Yes [ ] No Is it often difficult to open wide?

[ ] Yes [ ] No Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?

Signature :____ Date ___________________________

HEALTH HISTORY

Physician's Name________________________________ Ph #_________________ Date of last visit _________________

Are you presently being treated for any injury or illness? [ ] Yes [ ] No
Have you ever been hospitalized for an injury or illness? [ ] Yes [ ] No
Are you pregnant or planning to become pregnant? [ ] Yes [ ] No
Are you currently breastfeeding? [ ] Yes [ ] No
Are you required to pre-med with antibiotics before dental treatment? [ ] Yes [ ] No
Do you use alcohol? [ ] Yes [ ] No
Do you use or have you ever used tobacco? [ ] Yes [ ] No
Have you ever had an allergic reaction? [ ] Yes [ ] No List allergies ___________________________________

Do you have a history or are currently being treated for any of the followings
Digestive conditions? [ ] Yes [ ] No List conditions ____
Heart or Circulatory conditions? [ ] Yes [ ] No List conditions ____
Neurological conditions? [ ] Yes [ ] No List conditions ____
Lung or Breathing conditions? [ ] Yes [ ] No List conditions ____
Autoimmune conditions? [ ] Yes [ ] No List conditions ____
Head or neck injuries? [ ] Yes [ ] No List conditions ____
Artificial Joint? [ ] Yes [ ] No List conditions ____
Kidney disease? [ ] Yes [ ] No List conditions ____
Liver disease? [ ] Yes [ ] No List conditions ____
Thyroid disease? [ ] Yes [ ] No List conditions ____
History of cancer? [ ] Yes [ ] No List conditions ____
Tumor or abnormal growth? [ ] Yes [ ] No List conditions ____
Radiation therapy? [ ] Yes [ ] No
Chemotherapy? [ ] Yes [ ] No
HIV / AIDS? [ ] Yes [ ] No
High cholesterol? [ ] Yes [ ] No
Osteoporosis / osteopenia? [ ] Yes [ ] No
Type I or Type II diabetes? [ ] Yes [ ] No
Anemia? [ ] Yes [ ] No
Epilepsy? [ ] Yes [ ] No
Psychiatric care ? [ ] Yes [ ] No
Tuberculosis? [ ] Yes [ ] No
Measles / chicken pox? [ ] Yes [ ] No
Any other medical condition we should know of? List conditions ____

Are you taking any pain medications? ____
Are you taking any Antidepressants or Anxiety medications? ____
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications? ______________________________________
Are you taking any Allergy or Asthma medications? ____
Are you taking any Antibiotics? ____
Are you or have you ever taken Bisphosphonates (eg. Fosamax, Actonel)? ______________________________________
Are you currently taking any other medications or dietary supplements? ____

Signature :____ Date _____________________________