NEW PATIENT INFORMATION FORM

NAME_____

PREFERRED NAME _____

ADDRESS_____

CITY_____STATE_____ ZIP_____

DATE OF BIRTH_____ SEX: M /F MARITAL: S/ M/ D/ W

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____EMAIL_____

REFERRED BY: _____

INSURANCE INFORMATION

SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____

ADDRESS IF DIFFERENT FROM ABOVE _____

DOB _____ SS OR ID# _____

EMPLOYER_____ _____

INSURANCE CO: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE: _____GROUP # _____
DO YOU HAVE SECONDARY INSURANCE? YES_____NO____

I understand that my insurance is an agreement between my insurance company and me.
I also understand that I am responsible for my balance regardless of my insurance.
Please initial _____

I assign dental benefit payments to be paid to Dr. Boyse from my insurance company.
SIGNATURE OF RESPONSIBLE PARTY_____
ADDRESS _____PHONE_____

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We will only share information with your insurance company, other offices that we may refer you to for dental treatment, and individuals you have given written permission to discuss your treatment with.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. If you are a member of U.S. or foreign military forces and if required by the appropriate authorities.
6. To federal officials for intelligence and national security
7. To correctional institutions or law enforcement officials
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request for amendment.
2. Right to a copy of this notice. You may ask us to give you a copy of this Notice at any time.
3. Right to file a complaint if you believe your privacy rights have been violated. All complaints must be submitted in writing.
4. Right to provide an authorization for other uses and disclosures.

Patient or guardian signature if patient is under 18 years of age

Print Name _____

Signature_____ Date_____

Please list anyone that you would like us to be able to share your dental treatment with:

OFFICE POLICIES

Appointments

Patients are seen by appointment only. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep an appointment please notify us immediately. It is difficult to reschedule on the hygienists schedules since most appointments are made six months in advance. So please cancel only due to an emergency.

Insurance

If you have dental insurance, we will help you determine the coverage you have available. We ask that you assign your insurance benefits to us and by signing this form you are approving the release of information regarding your dental treatment to your dental insurance provider. At the time of treatment, you are responsible for paying your deductible and ESTIMATED co-pay, which is determined by the information supplied by you and your insurance company. It is important you keep us informed about any changes in your insurance. After 45 days, if we have not received payment from your insurance company, or if there is any balance after their payment, that balance is due by you.

Financial Policy

All deductibles and patient percentages are due at the time of treatment. You are fully responsible for all costs, regardless of insurance payment or coverage. If you do not have dental insurance, payment in full is due at the time of treatment. For major services (over $500) financial arrangements can be made to fit your individual needs. We accept checks, cash, Visa and Mastercard.

Notice of Privacy Practices (HIPPA)

A copy of our office Notice of Privacy Practices (HIPPA) is available for you to review. Upon request you may have a copy. You will be asked to sign our form and write the names of anyone we may discuss your dental information with.

Authorization

By signing this form, I authorize Dr. Boyse to administer anesthetics and perform any diagnostic, preventative and/or emergency treatment he deems necessary or beneficial. If consent is given for a child, by signing this form it applies whether or not I am present at the appointment when treatment is given.

Print patient's name _____
SIGNATURE:_____ **Date**_____

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes, reason:_____

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

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

1. _____
2. _____
3. _____
4. _____

For the following questions 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 Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Serzone® (nefazodone)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Barbiturates (any)	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Osteoporosis medications (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

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

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
If no, 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? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?
What is your normal blood pressure? S /D Today: _____/_____

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 or other sedatives…… No Yes
e. Latex or Metals
f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____
_____

Significant findings from questionnaire or oral interview:

_____
_____

Dental management considerations:

_____
_____

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 change in my health and medication.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*