MEDICAL HISTORY

To help us to provide you with the safest and best care, please complete this Medical History form. All information is kept strictly confidential

Have you taken any prescription drugs during the last 6 months? Please list **YES NO**

Are you taking any over the counter medications or herbal supplements? Please list: **YES NO**

Are you under a physician's care? If so, name and phone # of Physician: **YES NO**

Have you had any surgeries and/or hospitalization? **YES NO**

Are you now having or have you ever had radiation to the head or neck? **YES NO**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Please list: **YES NO**

Have you ever taken bone density medications for cancer or osteoporosis? **YES NO**

Have you ever or are you currently taking blood thinners? **YES NO**

Do you use tobacco? What type and how much per day? **YES NO**

Do you drink alcohol? If so, how much and how often? **YES NO**

Do you use any illegal substances? If so, which ones? **YES NO**

Are you pregnant? **YES NO** | Taking birth control? **YES NO** | Plan to become pregnant? **YES NO** | Nursing? **YES NO**

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Peanuts ◯ Codeine ◯ Acrylic ◯ Local Anesthetics
◯ Metal ◯ Latex ◯ Bananas ◯ Sulfa Drugs ◯ Other ◯ NONE

Mark any of the following that are not or were previously applicable:

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

Other, please explain:

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 office of any changes in medical status.

Print Patient Name

Signature of Patient or Guardian Date

Registration and Dental History

Patient's Name (First): (Last): (Middle Initial):

Preferred Name: Date of Birth: Age: Sex: **MALE FEMALE**

Address : City, State, Zip:

Cell Phone#: Work #: Other #:

E-Mail: Best Contact: **EMAIL TEXT CELL HOME**

Social Security#: Driver's License #:

Marital Status: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Spouse's Name or (If a minor) Parent's Name:

Spouse's Work Phone: Cell #:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (if different from patient): Relationship:

Responsible Party Address, City, State, Zip:

Home Phone#: Work #: Cell #:

Employer: Employer Address:

INSURANCE & EMPLOYER INFORMATION

Insurance Carrier Name:

Subscriber's Name: Subscriber's Date of Birth:

Relation to Patient: **SELF SPOUSE CHILD OTHER** Subscriber's Phone #:

Subscriber's SS#: Insurance ID #: Group #:

Insurance Carrier Address, City, State, Zip:

Medicaid #:

Employment Status: **FULL TIME PART TIME UNEMPLOYED** Student Status: **FULL TIME PART TIME**

Employer: Phone #:

Employer Address, City , State, Zip:

DENTAL INFORMATION

Do your gums bleed when you brush? **YES NO Don't Know**

Have you ever had orthodontic (braces) treatment? **YES NO Don't Know**

Are your teeth sensitive to cold, hot, sweets or pressure? **YES NO Don't Know**

Do you have earaches or neck pains? **YES NO Don't Know**

Have you had any periodontal (gum) treatments? **YES NO Don't Know**

Do you wear removable dental appliances? **YES NO Don't Know**

How do you feel about the appearance of your teeth?

If you have a current dental problem, how would you describe it?

What was the name of your previous dentist? Office#:

Date of your last dental exam: Date of your last dental x-rays:

What was done at that time?

EMERGENCY CONTACT

Emergency Contact: Phone/Cell #:

(Please list closest relative or friend whose address is different from yours)

Relationship to Patient:

Emergency Contact Address, City, State, Zip:

Preferred Pharmacy: Phone #:

OTHER

How did you hear about us?

Have you or another member of your family been treated here? If so, who?

Would you like to receive appointment reminders via text messages; **YES NO** via email? **YES NO**

Serenity Family Dentistry Financial Policies and Release of Information

Thank you for choosing Serenity Family Dentistry for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

Please understand that processing your claim and payment of your bill is considered part of your treatment. So that we may better serve you, we ask you to please read, sign and return this form to us prior to your treatment. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us. All patients should provide accurate and complete insurance information prior to being seen by the doctor. We will ask that you present your insurance card upon check-in at each visit so that we can verify coverage and the estimated deductible/percentage for services.

- Deductible/estimated portion for office services are required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX, Care Credit.
- We will file your insurance claims for services as a courtesy. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- You will receive a statement each month from us as a reminder to follow-up with your insurance company to ensure your claim has been processed. The balance on your account is due in full 60 days after the date of service regardless of insurance payment.
- Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
- If your insurance company is one that reimburses you directly for services ex: Delta Dental, payment for services rendered will be collected in full at the time of service.
- Please be aware that some insurance plans have exclusions for services and/or waiting periods. Although we make every effort to notify you of such policies, we cannot be familiar with every insurance plan. You are responsible for any non-covered or denied services.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Please help us serve you and our other patients by keeping all scheduled appointments**.** If you are unable to keep an appointment please notify us (even after hours) at least 24 hours in advance 704.365.0006. Failure to notify us within less than 24 hours of your appointment may result in a minimum broken appointment charge of $45.00 per hour.

R**eturned Checks**: For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.

Past Due Accounts: Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Serenity Family Dentistry of any changes associated with my insurance status. I agree to make an in-full, prompt payment to Serenity Family Dentistry when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to Serenity Family Dentistry.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Serenity Family Dentistry has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature:_____ **Date:**_____

Serenity Family Dentistry

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE

OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

_____

_____

_____

to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

NOTICE OF PRIVACY PRACTICES

Serenity Family Dentistry has a Legal Duty to keep your personal health information private and to:

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical and dental information.
2. Follow the terms of the current notice.
3. Notify you in a timely manner of an accidental disclosure of your private health information.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.
3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.

PATIENT ACKNOWLEDGEMENT

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT/GUARDIAN NAME: (PRINT)_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ DATE: _____