Patient Information

Patient Name:_____

Address:_____City_____Zip _____

Home#_____ Work# _____Cell#_____

Email: _____

Occupation:_____ Employer:_____

Height_____ Weight_____ Date of Birth_____ Sex: M F

SS#_____ Referred by:_____

Emergency Contact:_____ Phone#_____

Responsible Party

Name:_____ Relationship:_____
Address:_____
Home#_____ Work#_____

Insurance Policy

Name of Insured:_____ Date of Birth_____

SS#_____ Employer:_____

Insurance Company:_____

Insurance Address:_____

Insurance Toll Free Phone#_____ Group # _____

Dental Questionnaire

1. When was the last time you had your teeth cleaned?_____
2. When was the last time you had dental work?_____
3. Do you have well or county water?_____
4. What over the counter oral rinses are you using?_____
5. Do you take fluoride supplements? Yes No
6. Have you ever had periodontal (gum) treatment? Yes No
7. Have you ever had orthodontic treatment? Yes No
8. Do you floss regularly? Yes No
9. Do your gums bleed when you brush or floss? Yes No
10. Have you ever been concerned about bad breath? Yes No
11. Do you consistently get a bad taste in your mouth? Yes No
12. May we take any needed dental xrays? Yes No
13. Circle type of toothbrush you are using: Hard Medium Soft Electric
14. What are your dental goals?_____

Patient Medical History

1. Have you ever been seriously ill? Yes No
   If yes, please explain._____
2. Have there been any changes in your general health lately? Yes No
   If yes, please explain._____
3. Is a medical doctor currently treating you? Yes No
   If yes, who & please explain._____
4. Please list any medications you take._____
   _____
5. Have you ever had major operation or been hospitalized? Yes No
   If yes, please explain._____
6. Have you had a physical exam within the last year? Yes No
7. Have you ever had to take antibiotics (**PRE-MED**) before having dental work? Yes No
8. Do you have chest pains upon exertion? Yes No
9. Have you ever had xrays for a tumor, growth, or other condition? Yes No
10. Please circle any from the list below that you are allergic to or have had reaction to:

penicillin	erythromycin	codeine
aspirin	sulfa drugs	local anesthetics
iodine	barbituratates	latex

other:_____

11. Are you currently using any recreational drugs? Yes No
12. Had you ever had a blood transfusion? Yes No
13. Do you have shunts for dialysis or any other condition? Yes No
14. Do you bleed for a long time when you cut yourself? Yes No
15. Do you have frequent or severe headaches? Yes No
16. Do you have sinus trouble? Yes No
17. Do you have painful or swollen joints? Yes No
18. Do you have frequent cold sores or mouth ulcers? Yes No
19. Do you have complaints about your ears/hearing? Yes No
20. Do you have frequent colds? Yes No
21. Do you wear contact lenses? Yes No
22. Do you use tobacco? Yes No
23. Are you nervous? Yes No
24. Have you ever had or now have any of the following diseases or problems:

Mitral Valve Prolapse	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Low Blood Pressure	Yes	No	Epilepsy	Yes	No
Heart Attack	Yes	No	Abnormal Bleeding	Yes	No
Heart Murmur	Yes	No	Jaundice	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Tuberculosis	Yes	No
Hepatitis	Yes	No	Venereal Disease	Yes	No
Seizures	Yes	No	Hives/Skin Rash	Yes	No
Stroke	Yes	No	Artificial Bones	Yes	No
AIDS (HIV)	Yes	No	Difficulty Breathing	Yes	No
Anemia	Yes	No	Pace Maker	Yes	No

For Women Only (questions 1-3)

1. Are you currently pregnant or suspect you may be pregnant? Yes No
   If yes, how far along are you._____
2. Are you currently nursing? Yes No
3. Are you taking birth control pills or hormonal replacement? Yes No

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All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. Please carefully review the above medical history you have provided before signing.

I have read and understand the above questions. I have answered all these questions truthfully to the best of my ability and knowledge.

Signature_____Date_____

Welcome to our Practice

Thank you for choosing our office for your dental care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

Financial Agreement

- I understand that payment for services is completely my responsibility.
- I understand that my insurance is an agreement between the insurance company and myself and not between Dr. Venet and the insurance company.
- We file insurance as a courtesy. We gladly accept and file all insurances. We are ONLY in network with Delta Dental Premier
- I must provide the correct dental insurance information for this office to accept insurance as a payment.
- If insurance cannot be verified or if I do not have insurance, I will pay in full with cash, check or credit card at time of service.
- I also understand that I am responsible for any balance over 30 days.
- I understand that if for any reason my account is turned over to a collection agency, I will be responsible for any and all fees to collect my balance.

Appointments

In order to give the most efficient care; we work within an appointment system. Our office hours are Monday through Thursday, 8am to 5pm. (Closed for lunch 1-2pm.) We make every effort to honor all time commitments and expect patients extend us the same courtesy. We are available when emergencies arise, and will do our best to give prompt consideration as needed. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment.

Cancellation Policy

I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least 24 hours in advance of my scheduled appointment time. I understand that I should call the office and confirm my appointment within 24 hours. Please note schedule changes will be accepted during regular office hours. I am aware that I may be charged a fee if I do not provide 24 hours notice of cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50.00. If you fail to show up for two appointments, we may not be able to schedule you any more appointments.

Parents

You may accompany children in the operatories by invitation only. However, we do require you remain in the building with minor children (under 18 years of age) for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

I CERTIFY THAT I HAVE READ, UNDERSTAND ANDAGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

Patient Name (please print):_____

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

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Venet Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Financial ☐ Dental ☐ Appointment reminders
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Dental
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Dental ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____