PETTY DENTAL

Your Home for Beautiful, Healthy Smiles!

Patient's Name: **Last_____________________, First______________________, Middle _________________**

Name you would like to be called: ____________________ Date of Birth: ___ / ___ / ______

Address: ____

City: _______________________________ State: _____________________________ Zip Code: __________

Cell Phone: ______________________ Work phone: _________________ Home Phone: _________________

Email Address: ________________________________If a student, name of school: ______________________

Employer:____Occupation/Position: ___________________

Gender: M_____ F_____ Marital Status: Single _____, Married ______, Divorced ______, Widowed ______

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EMERGENCY CONTACT:

Name: ____ Relation to patient: ______________________

Cell Phone: ___________________Work Phone: _______________ Home Phone: ______________________

Address (if different from above): _______________________________________City:___________________

State: ______________ Zip Code: ____________

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PERSON RESPONSIBLE FOR PAYMENT: **(if other than the patient above)**

____ Relationship to Patient:________________________

Place of Employment: ____ Birthdate: ____/____/_____

Cell Phone:________________ Work Phone: ______________________ Home: ________________________

Address (if different than above): ____

City: ______________________ State: __________ Zip Code: ___________

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AUTHORIZATION OF CARE AND PAYMENT FOR PATIENT

- **I consent to treatment needed or desired for the above-named patient. This may include, but is not limited to: Medications, Dental procedures, X-rays, Photographs and/or other studies performed by Dr. Petty, his hygienists, or assistants.**
- **I acknowledge full responsibility for payment of all charges for dental services, materials and/or lab fees. I agree to pay my portion AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE with the Treatment Coordinator. I understand that any account considered delinquent may be subject to billing charges, collection costs and/or attorney's fees.**

Signature: ______________________________Relationship to Patient _________________ Date: _________

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How did you hear about us? Google Reviews: _____ Facebook: ____ Website: ____ Building/Sign: _____

Your Family: _____________________________ Friends: ____________________Doctor: _______________

THIS PAGE IS *ONLY* IF YOU HAVE DENTAL INSURANCE

Is Patient covered by a Secondary Insurance policy? Yes________ No ______ If yes, please print another copy of this page or ask our team member for an additional insurance sheet for the secondary policy.

1. Who is the EMPLOYER that provides the insurance? ____

   Location of where they work: ____

2. Full Legal Name of Employee/Subscriber of the insurance: _______________________________________

   Relation to patient: ___________________ Their SSN: _____-_____-_____ Their DOB: ____/____/______

3. Address (if different from patient's): ____

   City: ____________________ State: ____________Zip: ___________

4. Phone numbers same as patient's? Yes __________ If different, please provide below:

   Their Cell Phone: _________________Work Phone: ________________Home Phone: _______________

5. Their MARTIAL status: Married _______Single _______ Divorced _______ Widowed ________

Please provide your insurance card(s), so a copy can be made. If you do not have a card, please provide:

Name of Dental Insurance Company ____

Subscriber/Member ID: _____________________ Group #: _____________________ Plan #: _______

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<u>It is important for you to read this entire section.</u>

Dental insurance is a benefit provided by employers to their employees. All benefit amounts and deductible rules are solely determined by the contract agreement between your employer and the insurance company. The dentist has **no** part in this process.

As a professional courtesy to our patients, our staff will file your insurance form for you. Our office has not signed any network contracts, but we make every effort to help you utilize your benefits by providing estimates of what your insurance might pay.

a) For companies that will mail us the check, **payment for YOUR deductible and copay is expected at the time of your appointment.** We will be glad to provide this estimated amount to you in advance of your appointment so you will know how much is expected.
b) Some insurance companies will not send the check to our office since we are not in their network, but will mail it to you. For those companies, we ask that you pay the full amount at the time of the appointment.

- I understand that Petty Dental is not in network with my insurance company.
- To the extent permitted by applicable law, I authorize release to my dental insurance carrier any information and documentation relating to claims for payment and/or any request for any pre-treatment estimate without any further authorization in the future.
- I authorize payment directly to Petty Dental from my insurance company.

Signature: ____ Date: ______________________________

(if other than patient)
Person Completing the form: ____

Relationship to patient: ____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Cancer Radiation Therapy
☐	☐	Cancer- Chemotherapy
☐	☐	Chest Pain
☐	☐	Cholesteroll
☐	☐	Colitis/Irritable Bowel
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells

Y	N	Conditions
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Trouble
☐	☐	Hemophilia
☐	☐	Hepatitis A, B Or C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lung Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Prolonged Bleeding
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Diseases
☐	☐	Shingles

Y	N	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

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___

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Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: ______________________________ **Date:** ____________

(If Under 18, Parent or Guardian Signature Required)

Authorization for Release of Information (Notice of Privacy)

Patient Name: ____ Date of Birth: ___________________________

Many of our patients allow family members such as their spouse, parents, or others to call and request dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to those authorized below.

I authorize ***Petty Dental*** to release my dental and/or financial information to the following individual(s) as noted. Please indicate below if you want financial information shared:

1.____ Relationship: _____________ Financial: Yes___ No___

2.____ Relationship: _____________ Financial: Yes___ No___

3.____ Relationship: _____________ Financial: Yes___ No___

Authorization to Leave Detailed Messages:

Occasionally it is necessary for the staff of *Petty Dental* to leave messages for patients. The purpose of these messages is to confirm appointments or to ask a patient or responsible person to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages.

Please mark your preference below:

_______ I authorize *Petty Dental* to leave detailed voicemails and/or text.
This is the phone # I would like messages left: ____

_______ I authorize *Petty Dental* to send detailed emails.
This is the email address I would like messages sent: _____________________________________

_______ I do **NOT** want any detailed messages left on voicemail, text or sent via email.

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or obtain a copy of the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail, text or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

Person Completing This Form Signature: ____ Date: _______________

Relationship to Patient (***if other than self***): ______________________________

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You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Patient Name: ____ Relationship to Patient (*if other than self*): _________

Signature: ____Date: ______________________

FOR OFFICE USE ONLY:

We attempted to obtain acknowledgement of receipt of our Notice of Practices, but acknowledgement could not be obtained because:

___Patient refused to sign ___Communication Barriers ___Other (please specify) ___________________________

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