SERENITY DENTAL CARE
TOUCHING HEARTS WITH EVERY SMILE

Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help.

Personal

Name _____
Last First MI Prefferred

DOB _____ SSN# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Mobile # _____ Work # _____ Email _____

Preferred contact method [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Preferred contact for Confirmations [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Preferred contact for recall [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Student Status if dependent is over 19 (for Insurance) [ ] Non Student [ ] Fulltime [ ] Parttime

How did you hear about us? [ ] Google [ ] Internet [ ] Website [ ] Insurance [ ] Referral

Referral Name _____ (We'd like to thank them)

Address & Home Phone

Please check if same for the entire family [ ]

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Insurance Policy 1

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child Subscriber DOB _____

Subscriber Name _____ Subscriber ID# _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Insurance Policy 1

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child Subscriber DOB _____

Subscriber Name _____ Subscriber ID# _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments _____

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Medical History Form

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help.

Medical History

Name _____
Last First MI

Name of Medical Doctor _____ City _____ State ____

Emergency Contact _____ Phone _____ Relationship _____

List of all medications that you are taking: (INCLUDING INJECTIONS)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking the medication PROLIA (Denosumab)? [ ] Yes [ ] No If yes, how often? _____

Are you allergic to any of the following? ANY OTHER ALLERGIES/FOOD/DRUG NOT MENTIONED?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Asprin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

_____
_____
_____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Heart Trouble	☐	☐	Liver Disease	☐	☐	HIV/AIDS
☐	☐	Bleeding Problems	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever			
☐	☐	Cancer	☐	☐	Joint Replacement	☐	☐	Sinus Trouble			
☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐	Stroke			
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Ulcers			
☐	☐	DO YOU HAVE A PACE MAKER?				☐	☐	Pregnancy Trimester [ ] Due Date			

Tabacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit? _____ Are you in pain? [ ] Y [ ] N

New Patients

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? [ ] Yes [ ] No

Do you have BiteWing x-rays that are less than 1 year old? [ ] Yes [ ] No

Name of former Dentist _____ City _____ State ____

Date of last cleaning and exam? _____

Signature: _____ Date: _____

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Financial Policy

Financial Policy - Please read and sign below

TO PATIENTS WITH DENTAL INSURANCE

We are happy to assist you if you have some form of dental insurance. Each plan is unique so we encourage you to read and understand your individual plan. We currently accept many dental insurance plans. We bill your insurance as a courtesy, Be mindful that when we bill out to insurance it is not a guarantee of payment. If insurance does not pay within 60 days, we reserve the right to request payment in full for services from you and let you request to collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

Cancelation Policy:

A friendly reminder to be respectful of our patient's time and the office schedule, we require at least 24 hour advanced notification if you are unable to honor your commitment. A $50.00 charge will be added to your account if you cancel your appointment without notice or on the same day of the appointment.

Thank you for your cooperation.

Print Name _____

Patient Signature _____

Legal Guardian (if under 18) _____

Date _____

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HIPAA

HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:
- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature _____

Date _____

Family Members we may release information to:

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone Number _____ Relationship _____

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone Number _____ Relationship _____