Blue Tooth Dental ◆ Patient Information and Consent to Treatment

This form must be filled out completely and signed before any treatment can be rendered.

Patient name: _____ Nickname: _____

Street address: _____ Age: ___ Cell phone: _____

City: _____, OH Zip: _____ Home phone: _____

Soc. security # _____ Work phone: _____

Marital status: _____ Date of birth: _____

Responsible party name: _____ Sex: Female ☐ Male ☐

Responsible party address: _____ Date of birth: _____

Dental insurance co. name: _____ Soc. security # _____

Policy holder's name: _____ Policy/group# _____

Emergency contact: _____ Policy holder's employer: _____

Referred by: Friend/relative ☐ Yellow pages ☐ Other_____ and phone # _____

MEDICAL HISTORY OF PATIENT -- CONFIDENTIAL

What dental concerns or problems do you have today? _____

Please rate your current dental health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please rate your current general health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Current medical doctor: _____ Date of last exam: _____

Address of med. doctor: _____ Ph. # of med. doctor: _____

Please check the box if you have now or have ever had any of the following: ✓

Heart disease	☐	Thyroid problems	☐	Stroke	☐	Diabetes	☐
Anemia	☐	Low blood pressure	☐	Glaucoma	☐	Pacemaker	☐
Sinus trouble	☐	Joint replacement	☐	Cough	☐	Epilepsy	☐
HIV or AIDS	☐	High blood pressure	☐	Blood diseases	☐	Cancer	☐
Emphysema	☐	Rheumatic fever	☐	Heart murmur	☐	Any surgery	☐
Jaundice	☐	Bleeding problems	☐	Tuberculosis	☐		
Ulcers	☐	Arthritis	☐	Hepatitis	☐		

Describe cancer or surgery (please include dates): _____

Do you have any other medical problems not listed above? YES ☐ NO ☐

If yes, briefly describe other medical problems: _____

Are you currently taking any medications or prescriptions? YES ☐ NO ☐

If yes, please list all medications or prescriptions you are taking: _____

Are you allergic to: penicillin☐ codeine☐ latex☐ local anesthetics☐ other_____

Have you been treated with radiation or chemotherapy? YES ☐ NO ☐

If yes, when? _____

If female, are you pregnant?	YES ☐	NO ☐	If yes, due date _____
If female, are you currently nursing?	YES ☐	NO ☐	If yes, how long? _____
Are you subject to prolonged bleeding?	YES ☐	NO ☐	If yes, why? _____
Are you subject to fainting spells?	YES ☐	NO ☐	If yes, why? _____
Do you smoke?	YES ☐	NO ☐	If yes, how long? _____
Other respiratory problems?	YES ☐	NO ☐	If yes, how long? _____
Have you had any blood transfusions?	YES ☐	NO ☐	If yes, when? _____

CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

By my signature below, I consent to the examination and treatment by Blue Tooth Dental, Inc.. I understand that dentistry is not an exact science and therefore the results of any treatments performed may vary from patient to patient. I understand that occasionally, additional treatment may be required. I realize the bill is my responsibility. I assign and authorize payments by the insurance company be directly paid to Blue Tooth Dental, Inc I agree to pay any balance due.

Signature _____ Date _____

Custodial parent or legal guardian must sign for consent to treatment if patient is a minor or legally incapacitated.

Relationship if minor: _____

Office Use Only
Medical History Update

Patient Name______________________ Birthdate____/____/____ Patient Number__________

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

____

____

____

Signature of Patient (or Guardian) Date

Update reviewed by Dr.__________________

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

____

____

____

Signature of Patient (or Guardian) Date

Update reviewed by Dr.__________________

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

____

____

____

Signature of Patient (or Guardian) Date

Update reviewed by Dr.__________________

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

____

____

____

Signature of Patient (or Guardian) Date

Update reviewed by Dr.__________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

BLUE TOOTH DENTAL
41 ELVA COURT
VANDALIA, OH 45377
(937) 890-0023

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its *Notice of Privacy Practices* from the time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private 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 Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____

Financial Policy

Welcome to Blue Tooth Dental. We are committed to your treatment being successful. This is our financial policy, which we ask you to read and sign prior to treatment.

Payment

We do ask that full payment is due at time of service. If you have dental insurance, you are responsible for your portion in full at the time of service.

For your convenience we accept Visa, MasterCard, Discover, money order and cash.
Unfortunately at this time we do not accept personal checks unless authorized by administration.

Dental Insurance

Processing your dental insurance is a courtesy offered by this office. We can not bill you medical insurance for any procedures. Please realize all co pays are just estimates and are not binding. Your balance will be reflected by your insurances final payment.

Minor Patient

The adult accompanying a minor is responsible for payment at the time of service.

Urgent Care Patients

Payment is due at the time of service. If you have dental insurance our office may not be able to verify and bill your company for any procedures.

Missed Appointments

Please realize that confirmation is just a courtesy. We do require a 24 hour notice to cancel your appointment, to avoid a cancellation fee.

Payment Plans

Our office does not offer payment plans.

You are ultimately responsible for any balance on your account. Our office does reserve the right to dismiss you if any of these terms are broken.
I have read the policy of Blue Tooth Dental and agree to the terms.

SIGNATURE DATE