PATIENT INFORMATION

Date
Last Name
First Name Middle
Sex: Marital Status:
Date of Birth
SSN
Address
City
State Zip Code
E-mail
Phone # Cell #
Contact preference:
Employer/School
Occupation
Employer/School Address
Employer/School Phone
Spouse Name
Spouse Date of Birth
Spouse SS#
Spouse Employer
Who may we thank for referring you?

DENTAL INSURANCE

Who is responsible for this account?
Do you have insurance?
Primary Insurance
Group # / ID#

Subscriber's Name
Date of Birth
Secondary Insurance
Group # / ID #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with

Name of Insurance Company(s) and assign directly to

Dr. all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Printed name of Patient, Parent, Guardian, or Personal Representative

Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit
Former Dentist
City/State
Date of last dental visit
Date of last dental X-rays

Click "Yes" or "No" to indicate if you have had any of the following:

Bad Breath ☐ Yes ☐ No
Bleeding/Swollen gums ☐ Yes ☐ No
Blister on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Smoke: per day_____ ☐ Yes ☐ No
Other Tobacco Use_____ ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between teeth ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Partial/Full Denture ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Mouth sores or growths ☐ Yes ☐ No

How often do you floss?
How often do you brush?

HEALTH HISTORY

Physician's Name _____ Phone Number _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Have you ever taken any of the group of drugs referred to as "fen-phen (weight loss drug)?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine) and Redux (defenfluramine). ☐ Yes ☐ No

Check "Yes" or "No" to indicate if you have had any of the following:

*Artificial Heart Valves ☐ Yes ☐ No
*Damaged Heart Valves ☐ Yes ☐ No
*Heart Attack ☐ Yes ☐ No
If yes, date: _____
*Heart Murmur ☐ Yes ☐ No
*Rheumatic Fever ☐ Yes ☐ No
*Mitral Valve Prolapse ☐ Yes ☐ No
Angina ☐ Yes ☐ No
If yes, Stable or Unstable
Cardiovascular Disease ☐ Yes ☐ No
Congest. Heart Failure ☐ Yes ☐ No
Coronary Art.Disease ☐ Yes ☐ No
High or Low Blood Pressure (circle) ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swollen Feet or Ankles ☐ Yes ☐ No
Arteriosclerosis ☐ Yes ☐ No
Bleeding Abnormally ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Blood Transfusion If yes, date: ☐ Yes ☐ No _____
Coumadin/Warfarin ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No

*Artificial Joint(s) ☐ Yes ☐ No
If yes, date: _____
Osteoporosis ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No
Acid Reflux/Ulcers ☐ Yes ☐ No
Hepatitis Type _____ ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
AIDS/HIV ☐ Yes ☐ No
Autoimmune Disease ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
Recurrent Infections ☐ Yes ☐ No
If yes, specify: _____
Systemic Lupus Erythematosus ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
If yes, specify:
Venereal Disease ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Mental Health Disorders ☐ Yes ☐ No
If yes, specify: _____
Neurological Disorders ☐ Yes ☐ No
Seizures ☐ Yes ☐ No

Diabetes Type I or II ☐ Yes ☐ No
Eating Disorder ☐ Yes ☐ No
Special Diet ☐ Yes ☐ No
Unexplained Weight Loss ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Chemotherapy/ Radiation Treatment ☐ Yes ☐ No
If yes, specify: _____
Cortisone Treatments ☐ Yes ☐ No
Tumor/Cancer ☐ Yes ☐ No
Muscular Sclerosis ☐ Yes ☐ No
Alcohol Dependency ☐ Yes ☐ No
Controlled Substance Dependency ☐ Yes ☐ No
Fainting or dizziness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
If yes: _____
Swollen Neck Glands ☐ Yes ☐ No
Other Not Listed: _____

MEDICATIONS

Please list any and all prescriptions or over-the-counter medicines you are taking and what the drug is treating:

_____
_____
_____
_____

ALLERGIES

Anesthetic ☐ Yes ☐ No
Aspirin ☐ Yes ☐ No
Barbiturates ☐ Yes ☐ No
Codeine ☐ Yes ☐ No
Epinephrine ☐ Yes ☐ No
Other(s) ☐ Yes ☐ No
Iodine ☐ Yes ☐ No
Latex ☐ Yes ☐ No
Metals ☐ Yes ☐ No
Penicillin ☐ Yes ☐ No
Sulfa ☐ Yes ☐ No
If yes, please specify: _____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT (Specify someone who does **not** live in your household.)

Name _____ Relationship _____
Home Phone _____ Work Phone _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful health history and my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

CANCELLATION POLICY: I understand I am required to give the office 24 hours notice when canceling an appointment as this time is reserved or there will be a $25 fee charged which I am responsible for.

_____ _____
Signature Date

FORUM DENTAL

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCOLSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For examples:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization white it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extents necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are so present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable interferences of

your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the heath or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosures of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complain to the US Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Contact Officer: Christy Burke
Telephone: 573-364-1821
Email: christy@forumdental.com

FORUM DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

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

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgement

_____**Other (Please Specify)**

_____

_____

ForumDental.com

FINANCIAL AND INSURANCE ASSISTANCE

PAYMENT POLICY

INSURANCE: We will assist you with acquiring your insurance benefits by filing your claim for each date of service treatment is performed. You must supply us with all necessary forms, information and policy numbers. We do this as a courtesy to you.

LEGAL CASES: We do not treat patients on a contingency bases: payment is due when treatment is rendered, even where legal cases are pending settlement.

FINANCIAL CHARGES: Any unpaid balance that is 90 days overdue will assume a 1.5% finance charge per month until balance is paid. A collections agency will be contracted if we are unable to collect the balance which does reflect on your credit report.

ACKNOWLEDGMENT

PAYMENT RESPONSIBILITY: I, _____, agree to assume full financial responsibility for my bills with Forum Dental, its doctors and/or entities in the event my insurance does not pay. I assume responsibility for understanding the terms of MY insurance policy. I understand I am responsible for obtaining authorization referrals from my primary care physician or insurance company if such is required under MY insurance policy.

Patient Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

I WILL BE PAYING BY ____ CASH ____ CHECK ____ CREDIT CARD ____ CITI HEALTH