PARTHENON DENTAL

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's First Name: _____ Patient's Last Name: _____

Preferred Name: _____ Birth Date: _____ Gender: ◯ Male ◯ Female ◯ Other

If minor, parents name(s): _____

Patient Mobile Phone: _____ Home/alt Phone: _____

Email: _____

Mailing Address: _____ City _____ State _____ Zip _____

Social Security Number: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Preferred Pharmacy: _____

INSURANCE INFORMATION: Q I have dental insurance Q Not covered by dental insurance Q Niko Membership Plan

Subscriber full name: _____ Subscribers Birth Date: _____

Subscriber's social security number: _____ Subscriber's employer: _____

Dental Insurance Co._____ Subscriber ID: _____ Group number_____

Relationship to subscriber: ❑ self ❑ parent ❑ spouse

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Allergies/hives
- ❑ Asthma
- ❑ Anemia/blood disorders
- ❑ Abnormal bleeding after extractions or surgery
- ❑ Artificial joint/valve
- ❑ Blood transfusions
- ❑ Cancer or tumor
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Drug or alcohol addiction
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hay fever/sinus trouble
- ❑ Head/neck injury
- ❑ Heart disease/attack/angina
- ❑ Herpes/cold sores
- ❑ Hepatitis A, B, or C
- ❑ High blood pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Hypoglycemia
- ❑ Kidney disease
- ❑ Low blood pressure
- ❑ Lung problems
- ❑ Migraines/frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Radiation treatments
- ❑ Rheumatic fever
- ❑ Seizures
- ❑ Stomach/intestinal disease
- ❑ Stroke
- ❑ Thyroid/parathyroid disease
- ❑ Tuberculosis

Do you smoke or use chewing tobacco?
❑ yes ❑ no

Do you take, or have you taken, Phen-Fen or Redux?
❑ yes ❑ no

Do you take, or have you taken Bisphosphonates?
❑ yes ❑ no

Are you taking Coumadin/blood thinners?
❑ yes ❑ no

Do you premedicate (take antibiotics) prior to dental appointments?
❑ yes ❑ no

Do you have any other health conditions not listed above?
❑ yes ❑ no If yes, please explain:

_____

Are you taking any prescription drugs, or over the counter drugs?
❑ yes ❑ no If yes, please list medications:

_____

_____

Women:

Are you pregnant, or possibly pregnant?
❑ yes ❑ no
If yes, what is your due date: _____

Taking oral contraceptives? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Aspirin/Ibuprofen/Tylenol/Advil
- ❑ Amoxicillin
- ❑ Codeine or other narcotics
- ❑ Epinepherine
- ❑ Hydrocodone/Vicodin
- ❑ Local anesthetics
- ❑ Latex
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Tetracycline

Do you have any other allergies not listed above?

❑ yes ❑ no If yes, please explain:

_____

Name of your physician:_____

Have you ever been hospitalized or had a major operation? ❑ yes ❑ no If yes, please explain :_____

_____

DENTAL HISTORY

Former Dentist: _____

When was your last visit? _____

Have you ever experienced any of the following?

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or Popping Jaw
- ❑ Food Between Teeth
- ❑ Grinding
- ❑ Loose Teeth
- ❑ Sensitivity
- ❑ Other:_____

Have you ever experienced a problem during dental care?

_____

_____

Do you have any fears, hesitation, or special requests regarding any dental care?_____

_____

What would you like us to do today?_____

Please add anything else you would like us to know about you:

AUTHORIZATION

I hereby consent to allow Parthenon Dental to obtain adequate information to diagnose my dental health. This may include the production of radiographs, performing diagnostics tests, administering local anesthetics, and communicating with other healthcare providers involved in my treatment. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any change in my medical status, I will inform my dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____Reviewed By:_____

All payments and co-payments are due on the day services are rendered.

FINANCIAL AGREEMENT AND CANCELLATION POLICY

FINANCIAL AGREEMENT

Payment for services is due at the time services are rendered.
Patients who have dental insurance are expected to pay the amount of their estimated co-pay and/or deductible at the time of service. As a courtesy to you, we submit the claims necessary to see that you receive the full benefit of your coverage; however, we cannot guarantee any estimated coverage. All charges you incur are your responsibility, regardless of your coverage.

CANCELLATION POLICY

Appointments made are time reserved specifically for you. As a courtesy, we do our best to remind you, but ultimately it is up to you to keep track of all upcoming appointments.
We understand that schedules change and respectfully ask for 48 business hours' notice to cancel or change an appointment. Appointments missed or cancelled with less than 48 business hours' notice will incur a cancellation fee of $125. If your appointment is longer than 1 hour, you will be charged $125 for each hour missed. This fee cannot be billed to dental insurance and will be your direct responsibility. We do, however, understand that emergencies occur, and we do accommodate for those rare instances.
We appreciate your understanding and cooperation as this allows us to offer unscheduled time to patients waiting to see us.

LATE ARRIVAL POLICY

If you arrive more than 10 minutes late, your appointment may need to be rescheduled to meet the needs of those who are on time for their pre-scheduled visit. If your appointment must be rescheduled, this will be considered a missed appointment and a cancellation fee will be incurred.
*Please note, late arrivals will not receive an extension of scheduled appointment time.

I have read and understand the Financial Agreement and Cancellation Policy of Parthenon Dental.

_____
(Patient Name-Please Print)

Patient Signature

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:
-Protected health information may be disclosed or used for treatment, payment or healthcare operations
-The practice reserves the right to change the privacy policy as allowed by law
-The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
-The practice may condition receipt of treatment upon execution of this consent
-I may be contacted by phone, email, or text regarding appointments. Unless otherwise noted, I consent to having messages left on any phone number that I have provided.

If you would like anyone other than yourself to have access to your appointments/records (ie a parent, spouse, or partner) please name the family members allowed:

_____

_____

_____

_____

Patient name: _____ Date

Patient signature: _____