Patient Information

Name (First and Last) _____ ☐ M ☐ F DOB_____/_____/_____

SS Number _____ Marital Status_____ Employer _____

Home Phone _____ Mobile _____ Email _____

Address_____

Emergency Contact

Name (First and Last) _____ Relationship _____

Phone _____ Email _____

Address _____

Primary Dental Insurance

Insurance Co. Name and Address _____

Subscriber's Name _____ Relationship to Patient_____

DOB ____/_____/_____ SS#_____ Subscriber ID _____

Employer/Group Number _____

Secondary Insurance

Insurance Co. Name and Address _____

Subscriber's Name _____ Relationship to Patient_____

DOB ____/_____/_____ SS#_____ Subscriber ID _____

Employer/Group Number _____

Dental History

Reason for your visit today _____ How would you describe your current dental problem (if any)? _____

Date of last dental exam _____ Date of last dental x-rays _____

How do you feel about the overall appearance of your teeth? _____

BLUEBIRD
FAMILY DENTISTRY
& ORTHODONTICS

Health History

(Circle yes or no)

Yes No Abnormal/Excessive Bleeding

Yes No Alzheimer's Disease

Yes No Anemia

Yes No Arthritis/Rheumatoid Arthritis/Gout

Yes No Artificial Heart Valve

Yes No Artificial Joint

Yes No Asthma

Yes No Blood Transfusion

Yes No Cancer

Yes No Congenital Birth Defects

Yes No Convulsions/Epilepsy/Seizures

Yes No Cortisone Medicine

Yes No Diabetes

Yes No Dry Mouth

Yes No Disease/Drug/Radiation Immunosuppression

Yes No Drug Addiction

Yes No Emphysema

Yes No Fainting Spells/Dizziness

Yes No Heart Attack/Failure

Yes No Heart Disease/Murmur

Yes No Heart Pacemaker

Yes No Hemophilia/Blood Disorders

Yes No Hepatitis: A, B or C

Yes No HIV+/AIDS

Yes No Hypertension/High Blood Pressure

Yes No Hypoglycemia

Yes No Kidney/Liver Conditions

Yes No Low Blood Pressure

Yes No Lung Disease

Yes No Mental health Disorder(s)

Yes No Mitral Valve Prolapse

Yes No Osteoporosis

Yes No Respiratory Problems

Yes No Rheumatic/Scarlet Fever

Yes No Sexually Transmitted Disease

Yes No Shingles

Yes No Sinus Problems

Yes No Sores or Ulcer in Mouth

Yes No Stroke

Yes No Systemic Lupus Erythematous

Yes No Thyroid Problems

Yes No Tuberculosis

Yes No Ulcers

Are you currently taking blood thinners? Yes No

Do you use tobacco? Yes No

Do you wear contact lenses? Yes No

Are you, or think you may be, pregnant? Yes No

Are you currently nursing? Yes No

Please list all prescription and over-the-counter drugs you are currently taking_____

Have you had an orthopedic total joint replacement? Yes No If yes, when?
_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

If yes, what antibiotic and dose?
_____

Are you allergic to any of the following (circle): Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Lodine Barbiturates Adhesive Tape Antibiotics Sulfa Drugs

Please list any additional allergies
_____

Please discuss any serious medical conditions, diseases, disorders or problems you currently have or have had, including any major hospital stays and surgeries, that is not listed on this form_____
_____

Primary Care Physician
_____

I certify that I have read and understand the above. I understand that the information I have given is correct to the vest of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I authorize the dental staff to perform the necessary dental services and to not hold them 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.

Patient/Parent Guardian Signature
_____

Date
_____/_____/_____

Office Policy and Consent

Insurance and Payment Policies

- Fee for service is required at time of service.
- Treatment appointments made that exceed $1000.00 will require half down to hold appointment time.
- For patients with Dental insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will gladly submit dental claims for you, however any and all account balances are ultimately your responsibility. All treatment plans shown to you are estimates of what insurance may cover, we do our best to be accurate with the information your insurance provides us with.
- We accept VISA, MasterCard, Discover, American Express and Care Credit as well as personal checks and cash.

Office Policies

- Your appointment time is specifically set for you. For the courtesy of the Doctor and other scheduled patients, we ask that you keep your scheduled appointments. If you must change or miss an appointment we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50.00, or no reappointment. This policy is strictly enforced due to our high volume of patients.
- Our office will provide confirmation calls and/or email and/or text messages to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in the necessity to reschedule your appointment.

Consent

I have read and understand the above information. By signing I hereby authorize the Doctor to perform any and all diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records.

Patient/Parent Guardian Signature _____ Date ____/____/_____

Health Information and Privacy Policy

Information we collect about you

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as other dentists and specialist, imaging facilities, laboratories and your insurance company. The personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

How your information is used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the parent or guardian and can be revoked in at any time with written request. The office does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

Safeguarding your personal and health information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in privacy policy. As a means of protecting your privacy policy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provides quality service to you. This office maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with this office.

Changes to our privacy policy

All new patients will review a copy of our privacy policy. The office occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your right to restrict use of information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I, the undersigned have reviewed and understand the above Health Information Privacy Policy for Bluebird Family Dentistry and Orthodontics and agree to its terms.

Patient/Parent Guardian Signature_____ Date____/_____/_____