MORGAN
FAMILY DENTAL

PATIENT INFORMATION

Name:_____ Date:_____
Last First MI

Address: _____
Street Apt/Ste City State Zip Code

Telephone: Hm _____ Wk _____ Cell _____ Gender (Circle): M / F State DL/ID #: _____

Date of birth: _____ SS #: _____ Race: _____ Status: Married ___ Single ___ Child ___

If patient is a minor, Parent/Guardian Name: _____ Relationship to Patient: _____

Email address : _____ Primary language spoken: _____

Insurance Policy Holder's Name: _____ SS#: _____ Date of birth: _____

Insurance Co.: _____ Group #: _____ Employer Name/Phone #: _____

Emergency Contact Name/Relationship/Phone #: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following?

AIDS	Yes No	Chest Pain	Yes No	Heart Murmur	Yes No	Neurological Disorders	Yes No
Anemia	Yes No	Diabetes	Yes No	Heart Valve Replacement	Yes No	Organ Transplant	Yes No
Angina	Yes No	Dizziness	Yes No	Hepatitis	Yes No	Portal Cath	Yes No
Arthritis	Yes No	Epilepsy	Yes No	High Blood Pressure	Yes No	Radiation Treatment	Yes No
Artificial Joints	Yes No	Excessive Bleeding	Yes No	HIV	Yes No	Rheumatic Fever	Yes No
Asthma	Yes No	Fainting/Seizures	Yes No	Kidney Disease	Yes No	Sinus Problems	Yes No
Blood Disease	Yes No	Glaucoma	Yes No	Leukemia	Yes No	Stents	Yes No
Cancer	Yes No	Heart Attack	Yes No	Liver Disease	Yes No	Stroke	Yes No
If yes, type: _____		Heart Disease	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No

List any other medical condition you feel the doctor should be aware of : _____

Please list any allergies you are aware of : _____

Have you ever had an allergic reaction to: Latex Local Anesthetics Sedatives Penicillin Codeine Aspirin Sulfa Drugs Other _____

Are you taking or have you taken any bisphosphonates (bone-density medications): Yes No Please specify: _____

List any medications you are currently taking: _____

Do you have any history of alcohol or nicotine use or substance abuse?: _____

If female, are you pregnant? Yes No If yes, when is your due date? : _____ Do you currently smoke or use tobacco products? : Yes No

Have you ever had any complications following dental treatment? : Yes No
If yes, please explain: _____

Have you been admitted to the hospital or needed emergency care during the past two years? : Yes No
If yes, please explain: _____

Are you under the care of a physician? : Yes No If yes, name/phone # of physician: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. I understand that providing incorrect or incomplete information can be dangerous to the health of the patient. If there are any changes in health, I will inform the dental clinic staff and doctors at the earliest opportunity.

Signature of patient, parent or guardian _____ Date _____

ACKNOWLEDGEMENT AND CONSENT

1. The undersigned hereby authorizes the doctor or his/her designee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I authorize and consent that the doctor and/or hygienist choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, payable and due at the time services are rendered unless other arrangements have been made.
3. I understand that it is my responsibility to advise the appropriate office staff of any changes in the information contained on this form.
4. I certify that I have read and understand all of the information above and that, to the best of my knowledge, all of the information provided by me is accurate and correct.

Patient Name (Print): _____ **Date:** _____

Signature of Patient, Parent or Guardian: _____ **Relationship to Patient:** _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

First Name Last Name

Name: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Office Manager.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office manager. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

ACKNOWLEDGEMENT

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information and to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If you are signing on behalf of the patient, please complete the following:

Patient's name: _____

Your relationship to the patient: _____

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Insurance Billing Policy and Authorization

As a courtesy, our dental practice is pleased to accept most dental benefits/insurance plans. However, if you become ineligible for coverage for any reason, please be aware that you are responsible for all fees incurred by you and/or your dependents.

Acknowledgement and Assignment of Benefits

I understand that my dental insurance is a contract between my insurance carrier and me and not between the insurance carrier and the dentist. I understand that I am responsible for payment of annual deductibles and patient portions, if any, at time of service. I agree that if my insurance company does not pay for any dental service received by me or anyone authorized to receive dental benefits under the terms of my insurance agreement, that I am responsible for the balance resulting from their failure to pay.

Should I need a pre-treatment estimate, I understand that the estimation of costs is subject to change. Change in the estimation would directly relate to the insurance company's determination and interpretation of my coverage.

By signing this form below, I authorize Morgan Family Dental's providers to use this signature as authorization of all my insurance claim submissions. I authorize release of information to all of my insurance carriers. I authorize payment to be made directly to Morgan Family Dental. I permit a copy of this authorization to be used in place of an original claim form. I understand that I am responsible for my bill and that Morgan Family Dental is acting as an agent to help me obtain payment from my insurance carrier.

First: Last:

_____ _____

Patient Signature Date