

PATIENT INFORMATION

Patient's Name _____
LAST FIRST MIDDLE

Patient's Address: Street, Apt # _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-mail _____ Name of Spouse or Parent if minor _____

Best way to contact you? Home Phone Cell Text Email

Social Security # _____ Date of Birth _____ Marital Status: Single Married
MONTH / DAY / YEAR

Employer _____ Occupation _____

Business Address: Street, Apt # _____ City _____ State _____ Zip _____

Preferred Pharmacy _____ Pharmacy Phone # _____

Previous Dentist _____ Referred By _____

Physician's Name _____ Physician's Phone # _____

Name of Emergency Contact _____ Phone # _____

Referred by: Radio Newspaper Phonebook Website Facebook Friends or Family _____

1. Do you have insurance that may cover any part of our service? Yes No

Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____
MONTH / DAY / YEAR

Policy Holder's Address: Street, Apt # _____ City _____ State _____ Zip _____

2. Are you covered under more than one policy? Yes No

Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____
MONTH / DAY / YEAR

Policy Holder's Address: Street, Apt # _____ City _____ State _____ Zip _____

I hereby assign all dental benefits which I am entitled to Dental Designs. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient or Guardian Signature _____ Date _____

PERSONAL INFORMATION

INSURANCE

ASSIGNMENT



DENTAL HISTORY | SMILE EVALUATION

Date _____ Patient Name _____

1. Please state briefly the reason for your visit? _____
2. How long since your last dental visit? _____
3. Yes No Do your gums bleed, feel tender or irritated? _____
4. Yes No Are your teeth sensitive to hot, cold or sweets? _____
5. Yes No Are any teeth loose? _____
6. Yes No Do you grind, clench or grit your teeth? _____
7. Yes No Does your jaw ever click or cause pain on opening or closing? _____
8. Yes No Did you ever wear braces? _____
9. Yes No Have you ever worn any dental appliances? _____
10. Yes No Have you ever had gum treatments? _____
11. Yes No Do you wear dentures or plates? _____
12. Yes No Do you floss your teeth? _____
13. Yes No Have you ever had any unpleasant dental experiences or anything about dentistry you strongly dislike?

14. Yes No Do you like the way your teeth look? Why? _____
15. Yes No Are you happy with the color of your teeth? Why? _____
16. Yes No Would you like for your teeth to be whiter? Explain _____
17. Yes No Would you like for your teeth to be straighter? Explain _____
18. Yes No Do you have spaces between your teeth that you want closed? Explain _____

19. Yes No Do you like the shape of your teeth? Explain _____
20. Yes No Do you have missing teeth that you would like to replace? Explain _____

21. Yes No Do you have old silver fillings that you would like to replace with tooth-colored fillings? Explain _____

22. Yes No Would you like to know more about any of our products or services? Explain _____

23. If you could change anything about your smile, what would you change? _____

DENTAL INFORMATION

SMILE EVALUATION

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. Yes No Are you under a physician care now? Why? _____ Date of last physical examination? _____
2. Yes No Have you ever been hospitalized or had a major operation? Please list: _____
3. Yes No Have you ever had a serious head or neck injury? Please list: _____
4. Yes No Are you taking any medications, pills, vitamins, herbs or drugs? Please list: _____
5. Yes No Do you take or have you ever taken Phen-Fen or Redux? When? _____
6. Yes No Have you ever taken Fosamax, Boniva, Actonal or any other medications containing bisphosphonates?
7. Yes No Are you on a special diet? Describe: _____
8. Yes No Do you use tobacco? Please list: _____
9. Yes No Do you use controlled substances? Please list: _____
10. Yes No WOMEN: Are you now or trying to get pregnant? Nursing? Taking oral contraceptives?
11. Who is your preferred Pharmacy? _____ Phone Number _____
12. Are you allergic to any of the following:
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other
 Type of reaction: _____

13. Do you have or have you had any of the following:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Gastric Reflux GERD | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Snore Sleep Apnea |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Defibrillator* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Troubles/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |
| | | <input type="checkbox"/> Hypoglycemia | | *Condition may require medication |

14. Yes No Have you ever had any serious illness not listed above? Please list: _____
15. Do you have any comments? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Name (Please print) _____ Date _____
 Patient or Guardian Signature _____ Date _____
 Reviewing Dentist Signature _____ Date _____

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.

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

Patient, Parent or Guardian Signature _____

Patient Name (Please Print) _____ Date: _____

I also understand that if I have questions or complaints, I may contact:

Dr. Lisa Holst
401 East Robinson
Knoxville, IA 50138

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Call our office at (641) 828-8778 for their contact information.

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Attempt was made by: _____ Date: ____ / ____ / ____

FOR OFFICE USE ONLY

CONSENT AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me: Dental and Medical

I hereby authorize Dental Designs to release the above described information to the following individual and/or organization:

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I also understand that I may revoke this information at any time by providing written notification to:

Dr. Lisa Holst | 401 East Robinson | Knoxville, IA 50138

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon the authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on until revoked. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient above, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient, Parent or Guardian Signature _____ Relationship: _____

Patient Name (Please Print) _____ Date _____

Received by: _____

Date: ____ / ____ / ____

Dental Designs by Holst & Associates
401 East Robinson
Knoxville, IA 50138
(641) 828-8778



RECORD RELEASE FORM

I, _____ hereby authorize
(PATIENT'S FULL NAME)

Dentist's Name _____

Dentist's Address _____

to provide the office of Dental Designs with copies of my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examination, findings, treatments, prognosis and copies of any and all other records including x-rays, which pertain to me.

Patient or Guardian Signature _____ Date _____