

MALLERY FAMILY DENTAL

Patient Last Name: _____ First Name: _____ MI: _____

(Single Married Divorced Widowed) (Male Female) DOB _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

E-Mail _____ Employer _____ Insured Name: _____

Social Security #: _____ Dental Insurance Co. _____

Group #: _____ Member ID #: _____ Drivers License #: _____ Exp: _____

How did you hear about our practice? Patient / Friend: _____ Staff Member: _____ Doctor: _____

Insurance Company _____ Search Engine: _____ Facebook _____ Twitter _____ Blog _____ Other: _____

RESPONSIBLE PARTY

Last Name _____ First _____ MI _____

Address _____ City _____ Zip _____

DOB _____ Social Security # _____

Home Phone _____ Work Phone _____ Mobile Phone _____

EMERGENCY CONTACT

Last Name _____ First _____ Phone # _____

Address _____

AUTHORIZATION- *Please Read This Carefully & Initial Each Topic*

_____ Mallery Family Dental provides insurance company billing as a courtesy to our patients. The patient portion of your services are estimated and due at the time of service. Any amount that is not paid by your insurance company is due by you. In addition, certain insurance companies have annual limitations which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for these charges in full.

_____ The claims we submit to insurance companies indicate that you have assigned these benefits to Mallery Family Dental. However, if you are paid by the insurance company instead of Mallery Family Dental, you then become responsible for the total account balance and payment would be expected immediately. You as a patient are always responsible for any charges that are not covered by your insurance company.

_____ We understand that emergencies arise that preclude you from keeping an appointment, but **PLEASE** remember that we have reserved an appointment time especially for you. We request that you give us at least a 24 hour notice to reschedule an appointment. Therefore a missed appointment fee of \$52.00 may be assessed if 24 hour notice is not given for changing or cancelling a reserved appointment.

Signature _____ Date _____

PATIENT REGISTRATION

HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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.

- Are you under a physician's care now? Yes No DR'S NAME? _____
- Have you ever been hospitalized/or major surgery? Yes No WHY & DATE? _____
- Are you taking any medications, pills, or drugs? Yes No **IF "YES" FILL OUT BACK OF SHEET**
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No WHAT & DATE? _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Women:** Are you Pregnant Nursing? Taking oral contraceptives?

Are you allergic to any of the following? CHECK FOR YES

- Aspirin Penicillin Amoxicillin Erythromycin Codeine Acrylic Metal Latex Local Anesthetics
- Sulfa Drugs Advil Tylenol Food Allergies Other _____

PLEASE CHECK ANY OF THE BELOW CONDITIONS YOU HAVE EVER HAD OR HAVE NOW

<input type="checkbox"/> AIDS/HIV Positive <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis / Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> **Artificial Joint ** ** PRE-MEDICATION MAY BE NECESSARY ** WHERE? _____ WHEN? _____ DR NAME: _____ PHONE #: _____ We will need to contact your Dr to get your Pre-Med regimen. <input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Breathing Problems <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chest Pains <input type="checkbox"/> Cold Sores / Fever Blisters <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting Spells/ Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Genital Herpes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever / Allergies <input type="checkbox"/> Heart Attack / Heart Failure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Pacemaker <input type="checkbox"/> Heart Trouble / Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hives or Rash <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stomach / Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Ulcers <input type="checkbox"/> Yellow Jaundice
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Have you ever had any serious illness not listed above? Yes No N/A _____

I ACKNOWLEDGE THAT I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT BY NOT DOING SO IT CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE AND DR OF ANY CHANGES IN MY MEDICAL STATUS PRIOR TO ANY TREATMENT.

Signature of Patient, Parent, or Guardian

Date

PLEASE MARK ANY OF THE FOLLOWING MEDICATIONS THAT YOU ARE TAKING:

I TAKE NO MEDICATIONS EITHER PRESCRIBED OR OVER THE COUNTER AT THIS TIME.

ACCUPRIL - QUINAPRIL	GLUCOTROL - GLIPIZIDE	RECLAST – ZOLEDRONIC ACID
ACTONEL – RISEDRONIC ACID		RESTORIL – TEMAZEPAM
ADDERALL – AMPHETAMINE	HUMALOG – INSULIN LISPRO	REQUIP – ROPINIROLE
ADIPEX – PHENTERMINE	HUMULIN - INSULIN	
ADVAIR – FLUTICASONE	HUMIRA – ADALIMUMAB	SEROQUEL - QUETIAPINE
AMBIEN – ZOLPIDEM	HYDROCODONE	SOMA - CARISOPRODOL
ASPIRIN	HYZAAR – LOSARTAN	SPIRIVA – TIOTROPIUM
ATIVAN – LORAZEPAM		STRATTERA - ATOMOXETINE
ATROVENT – IPRATROPIUM	IMITREX – SUMATRIPTAN	SYMBICORT – BUDESONIDE
AVANDIA – ROSIGLITAZONE		SYNTHROID - LEVOTHYROXINE
AVODART – DATASTERIDE	JANUVIA – SITAGLIPTIN	
		TAGAMET – CIMETIDINE
BENICAR – OLMESTARTAN	LABETALOL – TRANDATE	TEGRETOL - CARBAMAZEPINE
BENTYL – DICYCLOMINE	LANTUS – GLARGINE	THYROLAR – LIOTRIX
BONIVA – IBANDRONIC ACID	LASIX - FUROSEMIDE	TOPAMAX – TOPIRAMATE
BYSTOLIC – NEBIVOLOL	LEVOXYL – LEVOTHYROXINE	
	LEVEMIR – INSULIN DETEMIR	TRICOR – FENOFIBRATE
CALAN – VERAPAMIL	LEXAPRO – ESCITALOPRAM	
CAPOTEN – CAPTOPRIL	LIPITOR – ATORVASTATIN	ULTRAM – TRAMADOL
CARDIZEM – DILTIAZEM	LOPRESSOR - METOPROLOL	
CELEBREX – CELECOXIB	LYRICA – PREGABALIN	VALIUM – DIAZEPAM
CELEXA – CITALOPRAM		VASOTEC - ENALAPRIL
COMBIVENT – IPRATROPIUM	METFORMIN GLUCOPHAGE	VENTOLIN - ALBUTEROL
COREG – CARVEDILOL	MEVACOR – LOVOSTATIN	VESICARE – SOLIFENACIN
CORGARD – NADOLOL	MICARDIS – TELMISARTAN	VICTOZA – LIRAGLUTIDE
COUMADIN – WARFARIN	MIDAMOR – AMILORIDE	VOLTAREN – DICLOFENAC
COZAAR – LOSARTAN	MIRAPEX - PRAMIPEXOLE	
CRESTOR - ROSUVASTATIN	MOBIC - MELOXICAM	WELLBUTRIN - BUPROPION
CYMBALTA - DULOXETINE	MONOPRIL - FOSINOPRIL	WELCHOL - COLESEVELAM
CYTOMEL - LIOTHYRONINE		
	NORVASC - AMLODIPINE	XANAX – ALPRAZOLAM
DETROL LA – TOLTERODINE	NOVOLOG – INSULIN ASPART	
DIGOXIN – LANOXIN		ZANTAC – RANITIDINE
DILANTIN – PHENYTOIN	ONGLYZA - SAXAGLIPTIN	ZESTRIL – LISINOPRIL
DIOVAN – VALSARTAN		ZOCOR – SIMVASTATIN
	PAXIL - PAROXETINE	ZOLOFT - SERTRALINE
EFFEXOR - VENLAFAXINE	PHENEGAN - PROMAZINE	ZOVIRAX - ACYCLOVIR
ENALAPRIL - VASERETIC	PLAVIX - CLOPIDOGREL	
EVISTA - RALOXIFENE	PRAVACHOL – PRAVASTATIN	
	PREMARIN – ESTROGEN	OTHER:
FARXIGA - DAPAGLIFOZIN	PREVACID – LANSOPRAZOLE	
FLEXERIL - CYCLOBENZAPRINE	PRILOSEC – OMEPRAZOLE	
FLOMAX - TAMSULOSIN	PRISTIQ - DESVENLAFAXINE	
FLONASE	PROCARDIA - NIFEDIPINE	
FLOVENT - FLUTICASONE	PROVENTIL - ALBUTEROL	
FOSAMAX - ALENDRONATE	PROZAC – FLUOXETINE	

PRINTED PATIENT NAME _____

DATE _____

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

DATE: _____

PATIENT NAME: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITY IN THE FUTURE.

Please **Print** your name

Please **Sign** your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

- First Name Only Last Name Only Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation E-Mail Confirmation
 Work Phone Confirmation Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation E-Mail Confirmation
 Work Phone Confirmation Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representative) signature on this Acknowledgement but did not because:

- It was emergency treatment. _____
I could not communicate with the patient. _____
The patient refused to sign. _____
The patient was unable to sign _____
Other: _____

Signature of Privacy Officer

Date