

Today's Date: _____

Who referred you to our office? _____

Patient's Name: _____

Social Security # _____

Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work: _____ ext _____ Cell: _____

Pager: _____ Email: _____

Employer: _____ City _____ Occupation _____

Name of Spouse/Parent/Guardian (circle one) _____

Social Security # _____

Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work: _____ ext _____ Cell: _____

Pager: _____ Email: _____

Employer: _____ City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name: _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary

Secondary

Employee Name _____

Employee Name _____

Ins Co Name _____

Ins Co Name _____

Ins Co Address _____

Ins Co Address _____

City, St, Zip _____

City, St, Zip _____

Phone _____

Phone _____

Group/Policy # _____

Group/Policy # _____

Employee SS# _____

Employee SS# _____

Birthdate _____

Birthdate _____

Annual Deductible _____ Pays Pt? ___ No ___ Yes

Annual Deductible _____ Pays Pt? ___ No ___ Yes

Maximum Annual Benefit _____

Maximum Annual Benefit _____

Notes _____

Notes _____

ASSIGNMENT and RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation.

In consideration of the service(s) rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policies.

I consent to the taking of photographs, x-rays before, during, and after treatment and to the use of the same by the doctor in scientific papers or demonstrations.

I certify that I have read or have had read to me, the contents of this form.

I have read above. Signature _____ Date _____

Patient's Name _____

Medication List

Are you apprehensive about dental treatment? ___ No ___ Yes

Are you currently under the care of a physician? ___ No ___ Yes

If yes, for what reason? _____

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Do you have allergies? ___ No ___ Yes

If yes, please explain _____

Are you allergic to any medications or substances? ___ No ___ Yes

If yes, please explain _____

Do you have any problems with antibiotics or anesthetics? ___ No ___ Yes

If yes, please explain _____

Do you take appetite suppressants? ___ No ___ Yes Name of product: _____

Have you ever had any of the following diseases or medical conditions?

Heart Attack/Stroke ___ No ___ Yes Epilepsy ___ No ___ Yes

Cancer/Chemotherapy ___ No ___ Yes Seizures ___ No ___ Yes

Heart Murmur ___ No ___ Yes Fainting ___ No ___ Yes

Rheumatic Fever ___ No ___ Yes Diabetes ___ No ___ Yes

HIV/AIDS ___ No ___ Yes Tuberculosis ___ No ___ Yes

Hepatitis A ___ No ___ Yes Hemophilia ___ No ___ Yes

Hepatitis B ___ No ___ Yes Blood Transfusion ___ No ___ Yes

Hepatitis C ___ No ___ Yes High Blood Pressure ___ No ___ Yes

Hepatitis D ___ No ___ Yes Low Blood Pressure ___ No ___ Yes

Anemia ___ No ___ Yes Radiation Treatment ___ No ___ Yes

Mitral Valve Prolapse ___ No ___ Yes Kidney Problems ___ No ___ Yes

Artificial Bones/Joints ___ No ___ Yes Artificial Valves ___ No ___ Yes

Sinus Problems ___ No ___ Yes Severe Headaches ___ No ___ Yes

Asthma ___ No ___ Yes Frequent Headaches ___ No ___ Yes

Difficulty Breathing ___ No ___ Yes Emphysema ___ No ___ Yes

Venereal Disease ___ No ___ Yes Shingles ___ No ___ Yes

Herpes Type I ___ No ___ Yes Herpes Type II ___ No ___ Yes

Heart Surgery ___ No ___ Yes Pace Maker ___ No ___ Yes

Psychiatric Problems ___ No ___ Yes Glaucoma ___ No ___ Yes

Do you smoke? ___ No ___ Yes Do you consume alcohol? ___ No ___ Yes

Are you allergic to any of the following?

Penicillin ___ No ___ Yes Codeine ___ No ___ Yes

Aspirin ___ No ___ Yes Tetracycline ___ No ___ Yes

Erythromycin ___ No ___ Yes Germicides/Pesticides ___ No ___ Yes

Latex or Rubber Products? ___ No ___ Yes Other _____

For Women Only:

Birth Control Pills ___ No ___ Yes

Pregnant ___ No ___ Yes

Months: _____

Signature _____ Date _____

Donald J. Alexander, DDS

6802 St. Augustine Road

Jacksonville, FL 32217

(904) 733-4200

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Donald J. Alexander, DDS

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Dr. Donald J. Alexander. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purposes, as authorized in the Patient Consent form.

Print Name _____ Address _____

Signature _____ Date _____

Please check your preferred means of communication:

- You may contact me at my home telephone number and leave a message _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an unencrypted email at _____
- Other _____

Please list **authorized persons** with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed _____
2. _____ Date Added/Removed _____
3. _____ Date Added/Removed _____

*******For Office Use Only*******

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
- ___ Communication barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (please specify) _____

Staff Person's Initials _____