Patient Information Form

Date_____

Patient Name:_____ MI____ Last_____

Is the patient a Minor? YES NO Date of Birth_____ Age_____ M F

Name of Responsible Party: _____Relationship to Patient_____

Address: Street_____ City_____State_____

Zip_____ Phone: Home__(_____)_____ Mobile__(_____)_____

E-Mail address _____

Preferred method of contact? O Home Phone O Call Cell Phone O Text Cell O E-mail

Emergency Contact

In case of emergency, who should be notified? _____

Relationship to Patient_____ Phone #_____

Dental Benefit Plan Information

Primary Dental Plan Name_____ Phone #_____

Name of Insured_____ Date of Birth_____ ID #_____

Social Security #_____Patient Relationship to Insured_____

Employee Name _____

Secondary Dental Plan Name_____ Phone #_____

Name of Insured_____ Date of Birth_____ ID #_____

Policy #_____ Patient Relationship to Insured_____

Please provide office staff with your Dental Insurance Card to make a copy for reference.

Thank you!

******SEE REVERSE SIDE******

Medical History

Patient Name_____ Birthdate_____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your dental health. Thank you for answering the following questions.

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies: _____

_____

Are you allergic to any of the following? (Circle all that apply)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Sulfa drugs

Please list allergies/reactions to medications, or other allergies? _____

Have you ever been hospitalized or had an operation? _____

_____

Physician _____ Office_____ Tel. #_____

Are you currently under a physician's care? Explain_____

Have you taken antibiotic premedication before dental appointments? YES NO

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

Are you pregnant? YES NO Nursing? YES NO

Do you use tobacco? YES NO Do you use controlled substances? YES NO Do you vape? YES NO

Do you have, or have you had, any of the following? (Please check all that apply to you)

O AIDS/HIV Positive	O Cortisone Medicine	O Hemophilia	O Radiation Treatments
O Alzheimer's Disease	O Diabetes	O Hepatitis A	O Recent Weight Loss
O Anaphylaxis	O Drug Addiction	O Hepatitis B or C	O Renal Dialysis
O Anemia	O Easily Winded	O Herpes	O Rheumatic Fever
O Angina	O Emphysema	O High Blood Pressure	O Rheumatism
O Arthritis/ Gout	O Epilepsy or Seizures	O High Cholesterol	O Scarlet Fever
O Artificial Heart Valve	O Excessive Bleeding	O Hives or Rash	O Shingles
O Artificial Joint	O Excessive Thirst	O Hypoglycemia	O Sickle Cell Disease
O Asthma	O Fainting spells/dizziness	O Irregular Heartbeat	O Sinus Trouble
O Blood Disease	O Frequent cough	O Kidney Problems	O Spina Bifida
O Blood Transfusion	O Frequent Diarrhea	O Leukemia	O Stomach/Intestinal
O Breathing Problem	O Frequent Headaches	O Liver Disease	O Stroke
O Bruise Easily	O Genital Herpes	O Low Blood Pressure	O Swelling of Limbs
O Cancer	O Glaucoma	O Lung Disease	O Thyroid Disease
O Chemotherapy	O Hay Fever	O Mitral Valve Prolapse	O Tonsillitis
O Chest Pains	O Heart Attack/Failure	O Osteoporosis	O Tuberculosis
O Cold sores/fever blisters	O Heart Murmur	O Pain in Jaw Joints	O Ulcers
O Congenital Heart Disorder	O Heart Pacemaker	O Parathyroid Disease	O Venereal Disease
O Convulsions	O Heart Trouble Disease	O Psychiatric Care	O Yellow Jaundice

Have you ever had any serious illness not listed above? Explain_____

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 child's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____Date_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. The rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information. (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information with be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U. S mail, and/or as requested by you. We may send your other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the staff.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
8. Is there anyone that you provide permission to answer appointment confirmation calls? If yes, who: _____ relationship to you_____

I_____ date_____ do herby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from the time forward.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____

******SEE REVERSE SIDE******

Office Policy

We are dental prevention specialists. By seeing your Dental Hygienist on a regular basis, you help prevent dental disease and increase your bodies overall health.
A Dental Hygienist is not (by law) allowed to diagnose or restore cavities or periodontal disease. For areas of concern or suspected oral disease, we will refer you to a dentist or specialist (of your choice) for further evaluations, diagnosis, and treatment. We recommend our patients to have a yearly visit with their Dentist.

With your permission we will use your name and telephone number for an automated texting system to remind you of your upcoming appointment.

Financial Policy

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. Our fees are based on the quality materials we use, and the time, effort and skill required in performing your needed treatment. We will assist you with your benefit eligibility before treatment to help you calculate your costs. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.
Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates.

We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. We accept the following forms of payment: Cash, Check, Visa and MasterCard. Most dental insurances and Mainecare. For patients that are self-pay, payment is due the day of service. Please feel free to contact our staff at any time to discuss any concerns you may have. Thank you for understanding our Financial Policy.

Cancellation and Failed Appointment Policy

Failed and missed appointments create scheduling problems for our team as well as take opportunities from other patients. If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. We understand that life is busy. If an appointment is failed, you will receive a written warning by mail. If you fail a second appointment time. A FAILED FEE will be charged to your account in the amount of $25. If the patient's phone is "out of service" or not receiving calls, the patient is still responsible for keeping the scheduled appointment.

I have read and agree to the Office Policy, Financial Policy and the Cancellation Policy of Prevention Is Key.

SIGNATURE (PATIENT, PARENT or GUARDIAN) _____ Date: _____

Records Release Form

I, _____, hereby request and give my permission for _____
(patient, parent, or guardian) (previous dental office)

to provide Prevention Is Key with past periodontal charting and radiographs for _____
(Patient or child's name)

DOB_____

Signature: _____ Date: _____

(Patient, parent, or legal guardian if the patient is a minor)

Please have dental radiographs and periodontal charting sent to:

Email: preventioniskeyipdh@protonmail.com

OR

Mail: P.O Box 328 Milbridge, ME 04658

For any questions, please call Prevention Is Key at (207)598-6195.

Thank you!