WELCOME TO OUR PRACTICE

Appointment Date ______________________________

Name: ____
Last First MI

Preferred Name: ______________________________ **Title:** ______________________________

Gender: ❑ Male ❑ Female **Marital Status:** ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

SS#: ______________________ **Birthdate:** _______ /_______ /_________

Prev. Visit: _________________ **Email address:** __________________________ **Best time to call:** _____________

Home Phone#: _________________ **Mobile Phone#:** ________________________

Work Phone#: __________________ **Ext:** _____________ **Fax:** _________________ **Other:** __________________

Address 1: _____________________________________ **Address 2:** ____

City _____________________________________ **State** ____________________________ **Zip Code** ______________

The following is for: ❑ the patient ❑ the person responsible for payment ❑ both ❑ not applicable

Employer Name: ____ **Phone#:** ________________________

Address 1: _____________________________________ **Address 2:** ____

City: ___________________________________ **State:** ___________________________ **Zip Code:** ______________

The following is for: ❑ the patient ❑ the person responsible for payment ❑ both ❑ not applicable

Whom may we thank for referring you to our practice?

____

In an emergency who should be notified? Please enter Name and Phone number below:

____

INSURANCE INFORMATION

Primary Dental Insurance:

Name of Insured:

____

Last First MI

Birthdate: ______ /______ /_________ **ID:** ___________________________ **Group#:** _____________

Insured's Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________

Insured's Employer Name: ____
Employer Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________

Patient's relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insurance Plan Name: ____
Employer Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________

Insurance Authorization:
❑ By checking this box, I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance:

Name of Insured:

____

Last First MI

Birthdate: ______ /______ /_________ **ID:** ___________________________ **Group#:** _____________

Insured's Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________

Insured's Employer Name: ____
Employer Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________
Patient's relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insurance Plan Name: ____
Employer Address:
Address 1: _____________________________________ **Address 2:** _______________________________________

City: ___________________________________ **State:** __________________________ **Zip Code:** _____________

Insurance Authorization:
❑ By checking this box, I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

MEDICAL HISTORY

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

❑ *Pre-Med - Amox	❑ *Pre-Med - Clind	❑ *Pre-Med - Other
❑ Allergy - Aspirin	❑ Allergy - Codeine	❑ Allergy - Erythro
❑ Allergy - Latex	❑ Allergy - Other	❑ Allergy - Penicillin
❑ Anemia	❑ Arthritis	❑ Artificial Joints
❑ Blood Disease	❑ Cancer	❑ Diabetes
❑ Epilepsy	❑ Excessive Bleeding	❑ Fainting
❑ Head Injuries	❑ Heart Disease	❑ Heart Murmur
❑ High Blood Pressure	❑ HIV	❑ Jaundice
❑ Liver Disease	❑ Med List	❑ Mental Disorders
❑ Osteoporosis	❑ Other	❑ Pacemaker
❑ Radiation Treatment	❑ Respiratory Problems	❑ Rheumatic Fever
❑ Sinus Problems	❑ Stomach Problems	❑ Stroke
❑ Tumors	❑ Allergies	❑ Allergy – Hay Fever
❑ Allergy - Sulfa	❑ Asthma	❑ Dizziness
❑ Glaucoma	❑ Hepatitis	❑ Kidney Disease
❑ Nervous Disorders	❑ Pregnancy	❑ Rheumatism
❑ Tubercolosis	❑ Ulcers	❑ Venereal Disease
❑ Ever been hospitalized (illness/injury)	❑ Presently being treated for any other illnesses	❑ Taking medication for weight control (ie fen-phen)
❑ Taking dietary supplements	❑ Subject to frequent headaches	❑ A smoker or smoked previously
❑ Female: Taking birth control pills	❑ Female: Pregnant	

If any condition or alerts selected above needs further clarification, please explain below:

____

____

Do you take antibiotic premedication for your dental visits? ❑ **Yes** ❑ **No**
If yes, please explain in the box provided below: ______________________________

Are you currently taking Bisphosphonate? ❑ **Yes** ❑ **No**
Name of physician and their specialty:______________________________

Most recent physical exam and purpose:______________________________

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

List all medications, supplements, and/or vitamins taken within the last two years:

____

Please list any medications you are currently taking, one medication per line:

____

❑ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

DENTAL INFORMATION

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Previous Dentist name and how long you have been a patient there:

____

Date of most recent dental exam: ________________ **Date of most recent dental x-rays:** ____________________

I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely

What is your immediate concern?

____

Personal History, Check all that apply:

❑ Had an unfavorable dental experience

❑ Had complications from past dental treatment

❑ Had trouble getting numb

❑ Had any reactions to local anesthetic

❑ Had/have braces, orthodontic treatm

❑ Had your bite adjusted

❑ Had any teeth removed

If any of the checked boxes need further explanation, please describe:

____

PATIENT CONSENT FOR SERVICES AND FINANCIAL POLICY

The undersigned hereby authorizes Dr. Logan's office to take x-rays,study models,photographs, or any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis of the patient's dental needs. I also authorize the doctor to to perform any and all forms of treatment,therapy, and medication that may be indicated and further authorize and consent that the doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment of dental services provided in this office for myself or my dependents is payable at the time services are rendered.

❑ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

❑ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.

CONSENT FOR INTERNET COMMUNICATIONS

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

❑ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.