POTTS DENTAL

Patient Information

Patient Name:____(___________________) Date: ________________
Last First MI Preferred

○ Male ○ Female ○ Married ○ Single ○ Child ○ Other ___________________

How did you hear about our office? __________________ Name of person or office referring you: ___________________

Social Security #:_______________________ Birth Date: __________________ Email:______________________________

Phone (Home):________________________ Mobile #:_______________________ Occupation:______________________

Address: ____
Street Unit Number

Spouse or Responsible Party: ________________________ Relationship to Patient: _______________________________

In case of emergency, contact: ____
Name Phone Relationship

Health Information

Previous Dentist: ______________________________________ Estimated Date of Last Dental Visit: __________________

Estimated Date of Last X-Rays:____________________________ Reason for this visit: ____________________________

Are you taking any medications? Please list: ____

____

Have you ever had any of the following? Please check those that apply.

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Endocarditis
- ☐ Prosthetic Heart Valve
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy, Currently
- ☐ Prescribed Weight Loss Meds
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Tuberculosis
- ☐ Tumors
- ☐
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Antibiotics Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Other Anesthetic Allergy
- ☐ Other: _____________
- ☐ Other: _____________

Health Information - Continued

Have you ever had any complications following dental treatment? ○ Yes ○ No

If yes, please explain: ______________________________

Have you been admitted to a hospital or needed emergency care during the past two years? ○ Yes ○ No

If yes, please explain: ______________________________

Are you now under the care of a physician? ○ Yes ○ No

If yes, please explain: ______________________________

Name of Physician: ______________________________ Phone: ______________

Do you have any health problems that need further clarification? ○ Yes ○ No

If yes, please explain: ______________________________

What is your primary source of water? Well, county, bottled? ______________________________

Do you pre-medicate for dental appointments? ○ Yes ○ No If so, why? ______________

To the best of my knowledge, all of the preceding answers and the information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature:______________________________ Date: ______________

Insurance Information

Name of Insured: ______________________Is insured a patient? Y or N Employer: ______________

Relationship to Insured: Self Spouse Child Other Insured's Birth Date: ______________

SS# or ID# ______________ ** A social security or valid insurance ID# is required to verify insurance benefits**

Insurance Name: ______________ Phone#: ______________ Group # ______________

Do you have secondary insurance? Y o N

Name of Insured: ______________________Is insured a patient? Y or N Employer: ______________

Relationship to Insured: Self Spouse Child Other Insured's Birth Date: ______________

SS# or ID# ______________ ** A social security or valid insurance ID# is required to verify insurance benefits**

Insurance Name: ______________ Phone#: ______________ Group # ______________

Assignment of Benefits

I authorize the release of any dental information necessary to process claims as well as payment of dental benefits to Potts Dental/Dr. Derek Potts for services rendered.

Name/Signature______________________________ Date ______________

Preferred Pharmacy

Pharmacy Name: ______________________ Pharmacy Address: ______________________

Pharmacy Phone Number: ______________________

What is the most important quality for you in a relationship with a doctor? ______________________

As a provider, all of the following are important to us. However, we would like to know which is the most important to you? ○ Function ○ Comfort ○ Cosmetic ○ Longevity

When considering having treatment, which would be of most concern to you?

○ Fear ○ Time ○ Budget ○ Trust

Go to Page 3 – Informed Consent, Consent for Services & Notice of Privacy Practices

Informed Consent, Consent for Services
Notice of Privacy Practices

_____ I acknowledge Potts Dental requires a 48-hour notice to cancel or reschedule an appointment. If less than 48-hours, a $50 fee may be assessed. I understand that if I am more than 15-munites late, my appointment may need to be rescheduled.

_____ I understand Potts Dental will bill my insurance as a courtesy and may provide an estimated co-payment based on insurance information at the time. Ultimately, I am responsible for fees related to dental treatment rendered should my insurance terminate or not pay for services rendered. All patient co-payments are estimates only and not a guarantee of payment by Potts Dental or your insurance.

_____ I understand patient co-payments are due at the time services are rendered. Financial arrangements must be made prior to treatment being rendered. A service charge of 1.75% per month will be charged on all accounts on any unpaid balances exceeding 60 days unless a financial arrangement is in place and in good standing.

_____I have disclosed my health history information, including allergies, diseases and past procedures. I understand the need to disclose any prescription drugs that are currently being taken. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax or Boniva, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

_____ I hereby authorize Dr. Derek Potts and/or such associates/assistants, as he may designate, to perform procedures as may be deemed necessary or advisable to maintain my oral health. This includes teeth cleanings, x-rays, exams, etc.

_____ I understand my dental condition(s) and will discuss treatment options with Dr. Derek Potts and/or his designated associate/assistant. Dr. Potts and/or his designated associate/assistant will discuss the expected results of the procedure(s) or course(s) of treatment as well as the consequences should I choose not to go forward with treatment.

HIPAA

Potts Dental is required by law to maintain the privacy of protected health information and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. We may disclose your health information for different purposes, including to a specialist providing treatment to you. You may request a detailed copy of our Notice of Privacy Practices at any time.

_____ I acknowledge and understand the information provided regarding HIPAA and the privacy of my protected health information.

I have read the above conditions of treatment, payment information and Potts Dental office policies.

_________________________	_____________________________	________________
Name/Responsible Party	**Signature of Responsible Party**	**Date**