WELCOME TO SILVERBELL DENTAL CARE

TO HELP US MEET ALL YOUR DENTAL CARE NEEDS, PLEASE TAKE A FEW MINUTES TO COMPLETE ALL THREE PAGES OF THIS FORM. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK AND WE WILL BE HAPPY TO HELP YOU.

PATIENT INFORMATION:

NAME_____ **BIRTHDAY**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **CELL**_____ **WORK**_____

EMAIL_____

IF FULL TIME STUDENT, NAME OF SCHOOL _____ **CITY**_____ **STATE**_____

PATIENT'S OR PARENT'S EMPLOYER_____

HOW WERE YOU REFEREED? PHONE BOOK INTERNET FRIEND RELATIVE DRIVE BY

OTHER:_____ **FRIEND /RELATIVE'S NAME**_____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR ACCOUNT_____

ADDRESS_____ **HOME PHONE**_____

INSURANCE INFORMATION:

NAME OF DENTAL INSURANCE_____ **GROUP NUMBER**_____

ADRESS OF INSURANCE COMPANY_____

CITY_____ **STATE**_____ **ZIPCODE**_____ **PHONE NUMBER**_____

NAME OF EMPLOYER_____ **EMPLOYEE FULL NAME**_____

EMPLOYEE BIRTHDATE_____ **I.D. or SS#**_____

IF SECONDARY INSURANCE IS AVAILABLE, PLEASE PROVIDE US WITH THE INFORMATION.

RELEASE:

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) DENTAL CARE AND TREATMENT FOR THE PURPOSE OF EVALUATING AND/OR ADMINISTERING CLAIMS FOR INSURANCE BENEFITS OR TO ANOTHER DENTIST.

I HEARBY AUTHORIZE THE ASSIGNMENT OF MY DENTAL BENEFITS TO SILVERBELL DENTAL CARE, PC. BY SIGNING MY NAME TO THIS DOCUMENT, I ALSO AGREE TO ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY DENTAL SERVICES PROVIDED. FULL PAYMENT FOR SERVICES, OR ESTIMATED CO-PAYMENTS, ARE DUE THE DAY OF YOUR DENTAL VISIT. YOUR PAYMENT MAY BE MADE WITH CASH, CHECK OR ACCEPTED CREDIT CARD.

PATIENT'S SIGNATURE_____ **DATE**_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes _____

Comments:

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

Signature of Patient, Parent or Guardian:

X

Date:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ Date:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time contacting:

Contact Person: **Dr. Stanley Baird**

Telephone: 520-628-4222

Address: 1370 N. Silverbell Road #190 Tucson, AZ 85745

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

SECTION C: SIGNATURE AND ACKNOWLEDGMENT:

I have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out *treatment, payment, payment activities and health care operations only.* I also acknowledge receipt of the Notice of Privacy Practices from Silverbell Dental Care.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name:_____ Relationship to Patient_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- o Individual refused to sign
- o Communication barrier
- o An emergency situation prevented us from obtaining acknowledgement
- o Other:_____