

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: Policy Holder Child Preferred Name: _____

Responsible Party Other

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec #: _____ Drivers Lic: _____

Email: _____ I would like to receive correspondences via e-mail:

Referred by: _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Soc. Sec #: _____ Drivers Lic: _____

Dental Insurance Information

Policy Holder: _____ Relationship to patient: Self Spouse Child Other

Policy Holder Soc. Sec. #: _____ Policy Holder Birth Date: _____

Employer: _____ Ins. Company: _____

ID #: _____ Address: _____

Ins Company Phone #: _____ City, State, Zip: _____

Insurance is filed as a courtesy to our patients. If claims are not settled within 45 days, the balance is your responsibility

MOST INSURANCE COMPANIES DO NOT COVER 100% OF THE COST OF YOUR TREATMENT

Authorization and Release

I certify that I have read and understand the above questions to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X _____

Signature of Patient (or parent if a minor)



RIVER OAK DENTAL

JIM NICHOLS, D.D.S.

Patient Name: _____

Soc. Sec. No.: _____

Birth Date: _____

1. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

- | | | |
|-----|----|--|
| Yes | No | Is your general health good? |
| Yes | No | Has there been a change in your health in the last year? |
| Yes | No | Have you been hospitalized or had a serious illness in the last three years? |
| | | If YES, why? _____ |
| Yes | No | Are you being treated by a physician now? For What? _____ |
| | | Date of last medical exam? _____ Date of last dental exam? _____ |
| Yes | No | Have you had problems with prior dental treatment? |
| Yes | No | Are you in dental pain? |

2. HAVE YOU EXPERIENCED:

- | | | | | | |
|-----|----|--|-----|----|------------------------|
| Yes | No | Chest Pains (Angina)? | Yes | No | Dizziness? |
| Yes | No | Swollen ankles? | Yes | No | ringing in ears? |
| Yes | No | Shortness of breath? | Yes | No | Headaches? |
| Yes | No | Recent weight loss, fever, night sweats? | Yes | No | Fainting spells? |
| Yes | No | Persistent cough, coughing up blood? | Yes | No | Blurred vision? |
| Yes | No | Bleeding problems, bruising easily? | Yes | No | Seizures? |
| Yes | No | Sinus problems? | Yes | No | Excessive thirst? |
| Yes | No | Difficulty swallowing? | Yes | No | Frequent urination? |
| Yes | No | Diarrhea, constipation, blood in stools? | Yes | No | Dry mouth? |
| Yes | No | Frequent vomiting, nausea? | Yes | No | Jaundice? |
| Yes | No | Difficulty urination, blood in urine? | Yes | No | Joint pain, stiffness? |

3. DO YOU HAVE, OR HAVE YOU EVER HAD:

- | | | | | | |
|-----|----|---|-----|----|---|
| Yes | No | Heart disease? | Yes | No | AIDS or HIV infection? |
| Yes | No | Heart attack, heart defects? | Yes | No | Tumors, cancer? |
| Yes | No | Heart murmurs? | Yes | No | Arthritis, rheumatism? |
| Yes | No | Rheumatic fever? | Yes | No | Eye diseases? |
| Yes | No | Stroke, hardening of the arteries? | Yes | No | Skin diseases? |
| Yes | No | High blood pressure? | Yes | No | Anemia? |
| Yes | No | Asthma, TB, emphysema, lung disease? | Yes | No | Kidney, bladder disease? |
| Yes | No | Hepatitis, other liver disease? | Yes | No | Thyroid, adrenal disease? |
| Yes | No | Stomach problems, ulcers? | Yes | No | Diabetes? |
| Yes | No | Allergy to: drugs, foods, medications, latex? | Yes | No | Have you ever taken fen-phen, Redux, or any other prescription diet medication? |
| | | If yes, which ones? _____ | | | |
| Yes | No | Any reaction to epinephrine in the past? | Yes | No | Have you ever taken Fosamax, Aredia, Zometa, Actonel, or any other Bisphosphatate for Osteoporosis or cancer therapy? |

4. DO YOU HAVE, OR HAVE YOU EVER HAD:

- | | | | | | |
|-----|----|------------------------------------|-----|----|-----------------------------------|
| Yes | No | Treatment for chemical dependency? | Yes | No | Hospitalization/ Surgeries? _____ |
| Yes | No | Radiation treatments? | | | _____ |
| Yes | No | Chemotherapy? | | | _____ |
| Yes | No | Prosthetic heart valve? | | | _____ |
| Yes | No | Artificial joint? | Yes | No | Blood Transfusion? |
| | | | Yes | No | Pacemaker? |

5. ARE YOU TAKING:

- | | | | | | |
|-----|----|---|-----|----|----------------------|
| Yes | No | Recreational drugs? | Yes | No | Tobacco in any form? |
| Yes | No | Drugs, medications, over-the-counter medications (including Aspirin), natural remedies? | Yes | No | Alcohol? |
| | | If yes, Please list _____ | | | |

6. WOMEN ONLY:

- | | | | | | |
|-----|----|---|-----|----|-----------------------------|
| Yes | No | Are you, or could you be pregnant or nursing? | Yes | No | Taking birth control pills? |
|-----|----|---|-----|----|-----------------------------|

7. ALL PATIENTS:

- | | | |
|-----|----|--|
| Yes | No | Do you have, or have you ever had any other disease or medical problems NOT listed on this form? |
| | | If so, please explain _____ |
| | | _____ |

To the best of my knowledge, I have answered every question and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____

Date: _____

I give Dr Nichols/ Dr. Huntsman permission to use my photographs or X-Rays for educational purposes:



Notices of Privacy Practices Acknowledgement

**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____