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 ___Seperated ___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, Zomete, Actonel, or any other Bisphosphatnate 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:

_____

RIVER OAK DENTAL

JIM NICHOLS, D.D.S.

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: _____