New Patient Form

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

Date of Birth: ___/___/_____ Social Security #: _____ Email: _____

Primary Phone Number: _____Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Employer's Phone Number: _____

How did you hear about our office: _____

Emergency Contact

First Name: _____ Last Name: _____ Relationship: _____

Phone Number: _____ Address: _____

Date of Birth: ___/___/____ City: _____ State: _____ Zip Code: _____

Spouse Information

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

Date of Birth: __/___/____ Social Security: _____ Phone Number: _____

Employer: _____ Employer's Phone Number: _____

Insurance Information

Primary Insurance Company: _____

Policy Holder: _____ Date of Birth: ___/___/_____

Secondary Insurance Company: _____

Policy Holder: _____ Date of Birth: ___/___/_____

Payment Due at Time of Service

Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we require a 24 - hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $25.00, or no reappointment.

I understand that I am responsible for payment of services rendered by Cisco Dental, and responsible for paying and co-payment and deductible that my insurance does not cover, I am also responsible for any costs that my insurance does not cover due to Cisco Dental being an out of network provider. I hereby authorize the Cisco Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

Dental History

What concerns you most? _____

Are you having any discomfort at this time? _____ What is the discomfort? _____

Have you ever had your teeth straightened? (Traditional Braces, ClearCorrect, Etc.) _____

How often do you brush your teeth? _____ How often do you use dental floss? _____

Do you have bleeding gums? _____ Have you ever had gum treatment? _____

When was the treatment? _____

Medical History

Who is your Primary Physician? _____

Physicians Address/Phone Number: _____

List any serious operations you have undergone:

_____

Woman Only: Are you Pregnant? _____ Number of Weeks: _____

Check any of the following that applies to you:

- ☐ Abnormal bleeding
- ☐ Alcohol use
- ☐ Anemia
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lupus
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Tobacco Use
- ☐ Tuberculosis (TB)
- ☐ Venereal Disease
- ☐ Recreational Drug use
- ☐ Sickle Cell Disease
- ☐ Psychiatric Problems
- ☐ Low Blood Pressure

Check any of the following that you are allergic to?

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Sedatives
- ☐ Tetracycline
- ☐ Other _____

Preferred Pharmacy: _____

List any medications you are currently taking:

_____

_____

_____

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ Any of the Above

Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $25.00, or no reappointment.

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITIES IN THE FUTURE.

_____ _____
Print Patient Name Patient/ Guardian Signature

_____ _____
Legal Representative/ Guardian Relationship of Legal Representative/ Guardian

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe) _____

Initial of Privacy Officer _____

Notice of Privacy Practices Summary

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:

a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.

b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.

c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a. To you

b. As required by federal, state, or local law

c. If child abuse or neglect is suspected

d. Public Health risks for public health activities to prevent and control of disease.

e. Lawsuits and disputes in response to a court or administrative order.

f. Law enforcement to help law enforcement officials respond to criminal activities.

g. Coroners, medical examiners, and funeral directors

h. Organ or tissue donation facilities if you are an organ donor

i. To avert a threat to individual or public health or safety

III. Disclosures where we have to give you a chance to agree or object:

a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.

b. Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:

1. Right to inspect your health record and to receive a copy of your health record upon request.
2. Right to amend information in your health record you believe is inaccurate or incomplete.
3. Right to know to whom we have disclosed your health information.
4. Right to ask for limits on the health information data we give out about you.
5. Right to receive communication from us about your health information in alternate ways.
6. Right to a paper copy of the complete Notice of Privacy Practices.

Notice of Privacy Practices Receipt

I acknowledge that I have received the Notice of Privacy Practices for Cisco Dental.

Signature: _____ Date: _____

Consent for Radiographs

Patient: _____

Parent/Legal Guardian: _____

The use of dental radiographs, or x-rays, allows the doctor to detect dental problems early before serious damage is done to your child's teeth, gums, and supporting bones and structures. If these conditions are not detected until there are visible or painful signs of disease, your child's oral health can be seriously affected. Dental radiographs are a part of a comprehensive dental oral examination. Your insurance might not cover the x-rays.

Please indicate which you would like us to do:

☐ I have x-rays that were taken within 12 months and I have brought them with me.

☐ You can take new x-rays, which may or may not be covered with my insurance; however, I know I am responsible to pay for the x-rays if my insurance company does not pay for the x-rays.

☐ I do not want x-rays taken today. I understand that the dentist will not be able to do a full exam. I release Cisco Dental, Jarred K. Donald DDS from any responsibility for any condition which may be present in my child's mouth that remains undiagnosed as a result of my request that no dental radiographs be taken.

***** Cash patients: x-rays are included in the Exam cost stated..*****

_____ _____

Signature Date

Cisco Dental

Out-Of-Network Insurance Agreement

I, _____, understand that Dr. Jarred K. Donald, DDS, FAGD, is out of network with the insurance I have provided for Cisco Dental. I, _____, agree that the amount I am paying to Cisco Dental is my portion of the in network pricing my insurance company offers. I, _____, am also agreeing that the insurance portion check that will be sent to my mailing address will be delivered to the office. I, _____, am also agreeing that the Treatment plan that was given to me is just an ESTIMATE, I will be liable for any cost that my insurance does not cover. Lastly, I understand that if the check is not delivered to the office, I will then become responsible for the FULL amount that the insurance was estimated to pay.

INITIAL _____ If your dental plan is out of network with your dental provider there is a possibility you will be billed the amount for any amount not paid by your insurance plan. You will receive a statement following the receipt of your claim payment. At that time, please call our office to make payment arrangements.

_____

Patient Name

_____

Subscriber on Insurance Policy

_____

Date