CENTRAL PARK DENTISTRY
PERSONAL INFORMATION

Last Name First Middle

☐ Single
☐ Married
☐ Widow

Date of Birth Age

Street Address

Home Phone Work Phone

City State Zip

Social Security Number Cell Phone

Mailing address (if different from above)

If student, school attending

Person responsible for acct. Relationship

Employer Occupation

In case of Emerg. Contact - Name and Number

Dental Insurance Information:

Employer _____

Insurance Company Name _____

Social Security Number of Employee _____

Employee Name _____

Employee Date of Birth _____

Referred by

E-mail address

Consent for Treatment:

I hereby grant authority to Dr. Hansen or Dr. Hemming to administer any treatment; and to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of me. I understand that I will be consulted before any treatment is rendered.

Signature (Patient or Parent of Minor) Date

*Receive e-mail or text message to confirm appointments yes or no (circle one) *

Our Office Policy:

To enable us to establish the best relationship possible with our patients from the very beginning and to avoid misunderstandings in the future, we have established certain office policies. Please read these policies and sign below signifying you have read and understand our policies.

Each patient we treat is entitled to, and will receive, a thorough and careful examination. We are dedicated to the principle of doing our best in treating all patients with the highest quality therapy possible.

It is our office policy that **24 Hour Notice must be given** if you are forced to cancel an appointment. We do not charge for "broken appointments" (no-shows and last-minute cancellations.) However, **after two broken appointments, we will give send a missed appointment letter, after 3 broken appointments we will give your file an "inactive status" and special arrangements must be made to reactivate it.** Our purpose in establishing this policy is to avoid making patients wait long periods of time for an appointment. If we are given proper notice of a cancellation, it enables other patients who are waiting for treatment to be called.

Parents need not accompany their children to the treatment room. Children are often more cooperative when their parent is not in the same room. We will examine your child and determine what he/she needs and then the doctor will discuss this with you before treatment begins.

Signature (Patient or Parent of Minor)

Payment Policy:

It is customary to pay for dental services in full when treatment is rendered. We accept cash, check, Visa, Discover and MasterCard. We do file dental insurance, but any deductibles and co-insurance are due at the time services are rendered. If at any time financial arrangements need to be discussed, we ask that you contact our office coordinator prior to the appointment.

Signature (Patient or Parent of Minor)

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

Women: Are you

- ◯ Pregnant/Trying to get pregnant?
- ◯ Taking oral contraceptives?
- ◯ Nursing?

Are you allergic or sensitive to any of the following?

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

◯ Other If yes, please explain: _____

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

◯ AIDS/HIV Positive	◯ Cancer	◯ Excessive Thirst	◯ High Blood Pressure	◯ Parathyroid Disease	◯ Stroke
◯ Alzheimer's Disease	◯ Chemotherapy	◯ Fainting Spells/Dizziness	◯ High Cholesterol	◯ Psychiatric Care	◯ Swelling of Limbs
◯ Anaphylaxis	◯ Chest Pains	◯ Frequent Cough	◯ Hives or Rash	◯ Radiation Treatments	◯ Thyroid Disease
◯ Anemia	◯ Cold Sores/Fever Blisters	◯ Frequent Headaches	◯ Hypoglycemia	◯ Recent Weight Loss	◯ Tonsilitis
◯ Angina	◯ Congenital Heart Disorder	◯ Hay Fever	◯ Irregular Heartbeat	◯ Renal Dialysis	◯ Tuberculosis
◯ Arthritis/Gout	◯ Convulsions	◯ Heart Attack/Failure	◯ Kidney Problems	◯ Rheumatic Fever	◯ Tumors/Growths
◯ Artificial Heart Valve	◯ Cortisone Medicine	◯ Heart Murmur	◯ Leukemia	◯ Rheumatism	◯ Ulcers
◯ Artificial Joint	◯ Diabetes	◯ Heart Pacemaker	◯ Liver Disease	◯ Scarlet Fever	◯ Venereal Disease
◯ Asthma	◯ Drug Addiction	◯ Heart Trouble/Disease	◯ Low Blood Pressure	◯ Shingles	◯ Yellow Jaundice
◯ Blood Disease	◯ Easily Winded	◯ Hemophilia	◯ Lung Disease	◯ Sickle Cell Disease	
◯ Blood Transfusion	◯ Emphysema	◯ Hepatitis A	◯ Mitral Valve Prolapse	◯ Sinus Trouble	
◯ Breathing Problems	◯ Epilepsy or Seizures	◯ Hepatitis B or C	◯ Osteoporosis	◯ Spina Bifida	
◯ Bruise Easily	◯ Excessive Bleeding	◯ Herpes	◯ Pain in Jaw Joints	◯ Stomach/Intestinal Disease	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient;

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here (if under 18yo, print patient's name, but parent/guardian need to sign below)

_____

Signature of Patient, Parent or Guardian

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI maybe disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

Name Name

_____ _____

Name Name

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2014

This form does not constitute legal advice and covers only federal, not state, law.

Updated 10/2023