

**PATIENT INFORMATION**

Date:    /    /

Full Name: \_\_\_\_\_

 Male  
 Female

Birth Date:    /    /                      -    -

Social Security: \_\_\_\_\_

Email Address: \_\_\_\_\_

 (    )                      (    )                      (    )  
 Home Ph:                      Cell Ph:                      Work Ph:

Address: \_\_\_\_\_

City:    State:                      Zip:

Your Occupation:    Employer:

Spouse's Name:    Ph Number: (    )

Treating Dentist's Name: \_\_\_\_\_

Name nearest relative not living with you:    Ph Number: (    )

Do you wear dentures or partials? If yes, how old are they? \_\_\_\_\_

**YOUR DENTAL INSURANCE INFORMATION**

If you have dental insurance, please fill in all information.

Full Name on Insurance Card: \_\_\_\_\_

Birth Date:    /    /                      -    -

Social Security: \_\_\_\_\_

Name of Insurance Co:    Group No:

Employer:    City:

**REFERRED BY**
 Friend                       Radio  
 Yellow Pages                       Internet  
 News Paper                       Doctor  
 Magazine                       Other

**HEALTH RELATED QUESTIONS**

	Yes	No
Pain in region of ears	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin/Warfarin Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Regular Coffee Drinker	<input type="checkbox"/>	<input type="checkbox"/>
Regular Alcohol Drinker	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Malignancies	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Smoke/Chew Tobacco	<input type="checkbox"/>	<input type="checkbox"/>

**Please list any allergies:**

 \_\_\_\_\_  
 \_\_\_\_\_

Please describe any current medical treatment, impending operations, pregnancy, or other information that must be taken into consideration:

 \_\_\_\_\_  
 \_\_\_\_\_



**AUTHORIZATIONS**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

First payment is due at the time your impression is taken, and payment in full is required at the completion of services. **Lab relines are NOT included into the price of the denture. For any returned checks you will be charged \$20.00.**

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date:

**PATIENTS WITH INSURANCE**

I certify that I am covered by my Insurance Company and I assign directly to European Denture Center all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date:

**NOTICE OF PRIVACY PRACTICES (HIPPA Requirements)**

**The Practice:** *(Effective date: This notice is in effect as of 10/01/08.)*

- A. Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice’s legal duties and privacy practices with respect to your PHI.
- B. Under the Privacy Rule, the Practice may be required by State Law to grant access to maintain greater restrictions on the use or release of our PHI than that which is provided for under federal law.
- C. Is required to abide by the terms of this Privacy Notice.
- D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice
- E. provisions effective for your entire PHI that it maintains.
- F. Will distribute any revised Privacy Notice to you prior to implementation.
- G. Will not retaliate you for filing a complaint.

**PATIENT ACKNOWLEDGEMENT**

By initialing below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

\_\_\_\_\_  
Patient Initials:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date: