Patient Information

Date: _____

Section 1: Patient Information

Patient Name: _____ I prefer to be called: _____
Address: _____ City: _____ St: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____
Check appropriate box: ☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If student, name of school: _____
How did you hear about our office? _____

Employer

Patient's Employer: _____
Employer Address: _____ City: _____ St: ____ Zip: _____

Spouse

Spouse's Name: _____
Birth date: _____ SSN: _____ Driver's License #: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____

Emergency Contact

Person to contact in case of emergency: _____ Relationship to patient: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Section 2: Parent/Guardian Information (if patient is a child)

Mother: _____ Relationship: ☐ Mother ☐ Stepmother ☐ Guardian
Address: _____ City: _____ St: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____
Check the appropriate box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Father: _____ Relationship: ☐ Father ☐ Stepfather ☐ Guardian
Address: _____ City: _____ St: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____
Check the appropriate box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RockFamily® DENTAL
Affiliate of RockDental BRANDS

Section 3: Person Responsible for Account

Name: _____ Relationship to patient: _____
Billing Address: _____ City: _____ St: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____

Section 4: Insurance Information

Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____
Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following.

Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____

Dental History

Why have you come to the dentist today? _____
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently in pain? ☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Do you like your smile? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
How many times a week do you floss? _____ How many times a day do you brush? _____
What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

RockFamily® DENTAL
Affiliate of RockDental BRANDS

Medical History

Do you have a personal physician? ☐ Yes ☐ No Date of last visit?_____
Physician's name: _____ Main Phone: _____
Address: _____ City: _____ St: _____ Zip: _____
Are you currently under the care of a physician? ☐ Yes ☐ No If yes, please explain:_____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Please list any medications you are currently taking:

_____
_____
_____

Do you use tobacco in any form? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonate? ☐ Yes ☐ No
Have you ever taken Phen-Fen? ☐ Yes ☐ No
For women:
Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week #: _____ Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? Please check appropriate box.

- ☐ ADD/ADHD
- ☐ AIDS or HIV infection
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Convulsions
- ☐ Fainting/Seizures
- ☐ Fever Blister/Herpes
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Handicaps/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery/Pacemaker
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Kidney Diseases
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problem
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Stomach Troubles/Ulcers
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Other: _____

Please list any other serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following? Please check appropriate box.

- ☐ Aspirin
- ☐ Tetracycline
- ☐ Sulfur Drugs
- ☐ Erythromycin
- ☐ Latex
- ☐ Iodine
- ☐ Penicillin
- ☐ Jewelry/Metals
- ☐ Plastic
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Other: _____

Please list any other drugs/materials you are allergic to: _____

_____

Text and Email Policy

Rock Family Dental can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

Consent to Email and/or Text Message for Appointment Reminders and Other Communications:

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Communication Preference: ☐ Text ☐ Email

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. Any account that payment has not been received within 90 days will be considered for collection by an outside agency. For your convenience, our office offers the following method of payment: cash, check, Mastercard, Discover, American Express, and Care Credit. (Care Credit applications are available upon request.)

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurances does not cover. I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Patient name

_____ _____

Patient or Guardian Signature **Date**

Appointment Policy

We are glad you have made an appointment at our office. We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. Please take a moment to familiarize yourself with our appointment policy.

We require that you give our office **48 hours notice** in the event that your need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time, this is considered a missed or broken appointment.

Broken appointments make it difficult to maintain both a timely schedule for our patients and efficiency for our staff. If 2 broken appointments occur, our office reserves the right to not schedule any subsequent appointments.

We must be able to contact you **24-48 hours** prior to your appointment to confirm. We must have working phone numbers to contact you. If we leave a message, please call us back to confirm or you may be at risk of losing your appointment.

Please, contact our office and we will do our best to accommodate your situation if you have an issue with a scheduled appointment time.

I understand and agree to the above.

Patient Name Printed	Signature of patient, parent, or guardian	Date

Photo & Video Release

I hereby grant Rock Family Dental the right and unrestricted permission to use photos/videos taken of me (or my child), or in which I (or my child) may be included with others, and to use, reuse, publish and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising and trade, or any other purpose whatsoever without restriction.

Patient Name Printed	Signature of patient, parent, or guardian	Date

RockFamily® DENTAL
Affiliate of RockDental BRANDS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ **Relationship to Patient** _____

Signature _____ **Date** _____

Please, list below any person who can receive PHI (Protected Health Information) on this patient.

Name	**Relationship**	**Treatment info**		**Ledger**	
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No

OFFICE USE ONLY *I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:*

Date Initials Reason