Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Date _____
Last Name First Name Initial

Mailing Address _____
City_____

State _____ Zip _____

Home#_____ Work#_____ Cell#_____

Email_____ SSN_____

Sex: M / F Birthdate _____

Marital Status • Single • Married • Divorced • Separated • Widowed

Employer_____ Occupation
_____

In case of emergency who should be notified _____

Relationship to patient_____

Phone _____

AUTHORIZATION

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of insurance benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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Patient Information

Medical History

Physician's Name_____ Date of Last Visit_____

Pharmacy: _____ Location_____

Have you had any serious illnesses or operations ❑ yes ❑ no. If yes, describe

_____

Have you ever had a blood transfusion? ❑ yes ❑ no. If yes, give approximate dates _____

(Women) Are you pregnant? ❑ yes ❑ no Nursing ❑ yes ❑ no Taking birth control pills? ❑ yes ❑ no

Check if any of the following applies to you:

❑ **AIDS** ❑ **Cortisone Treatment** ❑ **High Blood Pressure** ❑ **Skin Rash**
❑ **Anemia** ❑ **Cough, Persistent** ❑ **HIV Positive** ❑ **Swelling of Feet**
❑ **Arthritis, Rheumatism** ❑ **Diabetes** ❑ **Kidney Disease** ❑ **Stroke**
❑ **Artificial Heart Valves** ❑ **Epilepsy** ❑ **Liver Disease** ❑ **Thyroid Problems**
❑ **Artificial Joints** ❑ **Fainting** ❑ **Mitral Valve Problems** ❑ **Tobacco Habit**

❑ **Asthma** ❑ **Glaucoma** ❑ **Nervous Problems** ❑ **Tonsillitis**
❑ **Blood Thinners** ❑ **Headaches** ❑ **Pacemaker** ❑ **Tuberculosis**
❑ **Back Problems** ❑ **Heart Murmur** ❑ **Psychiatric Care** ❑ **Ulcer**
❑ **Blood Disease** ❑ **Heart Problems** ❑ **Radiation Treatment** ❑ **Venereal Disease**
❑ **Cancer Describe_____** ❑ **Respiratory Disease** ❑ **Chemical Dependency**
❑ **Hemophilia** ❑ **Rheumatic Fever** ❑ **Chemotherapy** ❑ **Hepatitis**
❑ **Scarlet Fever** ❑ **Circulatory if yes, type_____** ❑ **Shortness of Breath**

MEDICATIONS

List ALL medications you are currently taking.

_____ _____

_____ _____

Allergies to medications:

_____

Patient Consent Form

Russell Davis Dentistry
409 North Main Street
St. Martinville, LA 70582

I understand that, under the Health Insurance Portability and 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, but is not mandatory for me to sign in order to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Receive communications regarding my appointments via mail in post cards and/or phone and text messages.

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the option to receive a copy of your *Notice of Privacy Practices* upon signing this consent. 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 current 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. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

You may release information regarding my treatment or my appointments to the following person(s):

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____