HIPPA Information and Consent Form

The Health Insurance Probability and Accountability Act (HIPPA) provide safeguards to protect your privacy. This form is a “friendly” version of what HIPPA is. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. Additional information is available from the U.S department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is our office policy to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You are to bring and concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposed of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.

I, ______________________________ on this date_______/_____/______do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information form and any changes in office policy. I understand that this consent shall remain in force from this time forward.

616 Dental Studio PLLC

171 Monroe Ave NW
Grand Rapids, MI 49503
(616) 214 - 7865

Patient's Name ______________________________ Date: _____________

Smile Evaluation

1. Do you like the way your teeth look?
   ____
2. Do you want your teeth to be whiter?
   ____
3. Would you like your teeth to be straighter?
   ____
4. Would you like to close any spaces between your teeth?
   ____
5. Would you like your teeth to be longer?
   ____
6. Do you like the shape of your teeth?
   ____
7. Would you like to replace any missing teeth?
   ____
8. Would you like to replace your silver fillings with tooth-colored ones?
   ____
9. If you could change anything about your smile, what would you do?
   ____
   ____

616 DENTAL STUDIO

616 Dental Studio PLLC

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Date ___________________

Patient Information

Name ____
LAST FIRST MI PREFERRED NAME

Address ____
STREET APT #

____
CITY STATE ZIP

Employer ______________________________ Driver License ________________________

Birth Date ________________ Marital Status: Married _____ Single ____ Other _____

Phone: Home (____) _____________ Social Security # ______________________
Work (____) _____________
Cell (____) _____________ Email ____________________________

Emergency Contact: Name __________________________ Phone (____) ____________

How did you hear about us? ____

Insurance

Primary Dental Carrier

Insurance Co Name: _________________________ Phone #: ______________________

Insured's Name: _______________________ Birth Date: ________ ID#: ____________

Insured's Employer: __________________________ Group #: ______________________

Relationship to Patient: ____________________________

Secondary Dental Carrier (if applicable)

Insurance Co Name: _________________________ Phone #: ______________________

Insured's Name: _______________________ Birth Date: _________ ID#: ___________

Insured's Employer: __________________________ Group #: ______________________

Relationship to Patient: ________________________

Please continue to page 2

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If Patient is Under 18 Years of Age

Responsible Party ____________________________ Relation to Patient_______________

Address____
Street City State Zip

The information on this page is correct to the best of my knowledge

____ _________________________
PATIENT OR PARENT/GUARDIAN SIGNATURE DATE

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Medical and Health History

Medical Evaluation

Physician's Name ____________________________ Physician's Phone _______________

Have you had a serious illness or operation? Y(____) N(____)

Are you currently under physician's care? Y(____) N(____)

If yes, please describe ____

____

Medical History and Information

Please check all conditions that have ever applied to you

<u>Conditions</u>

- Abnormal Bleeding
- Alcohol Abuse
- Arthritis
- Artificial Heart Valve
- Asthma
- Blood transfusion
- Cancer
- Heart Attack
- Joint Replacement
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Mitral Valve Prolapse
- Pace Maker
- Seizures
- Sinus Problems
- Tuberculosis
- Drug Abuse
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing

Please list any allergies ____

Do you smoke or use tobacco: Y (____) N (____)

Please list any medications you are currently taking:

____

____

Please continue to page 2

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Dental History

Reason for today's visit ____

Former Dentist ________________________ City/State ______________________

Date of last dental visit _________________ Date of last dental X-rays _________

Please indicate if you have had any of the following:

- Bad Breath
- Bleeding gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth
- Cigarette, pipe, or cigar smoking
- Clicking or popping jaw
- Dry mouth
- Fingernail biting
- Food collection between the teeth
- Foreign objects
- Grinding teeth
- Gums swollen or tender
- Jaw pain or tiredness
- Lip or cheek biting
- Loose tooth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to col Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in your mouth

How often do you floss?
____

How often do you brush?
____

Treatment Authorization

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

____ ________________________

PATIENT OR PARENT/GUARDIAN SIGNATURE DATE