Case #: _____

Patient Information

Patient Name: _____ Date: _____

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best Time to Call: _____

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Address: _____

_____

Health Information

Date of Last Dental Visit: _____ Reason For Visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Kidney Disease	☐ Stomach Problems
☐ Allergies	☐ Fainting	☐ Liver Disease	☐ Stroke
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Head Injuries	☐ Pregnancy	☐ Venereal Disease
☐ Blood Disease	☐ Heart Disease	☐ Radiation Treatment	☐ Codeine Allergy
☐ Cancer	☐ Heart Murmur	☐ Respiratory Problems	☐ Penicillin Allergy
☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	MEDICATIONS:
☐ Dizziness	☐ High Blood Pressure	☐ Rheumatism	☐ _____
☐ Epilepsy	☐ Jaundice	☐ Sinus Problems	☐ _____

Do you have any current dental concerns? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician? _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of Patient, Parent or Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient, Friend ☐ Another Patient, Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other: _____

Name of Person or Office Referring You to Our Practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other:

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best Time to Call: __________

Address: ______________________________

____

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best Time to Call: __________

Address: ______________________________

Insurance Information

Primary

Name of Insured: ______________________________ (Last / First / MI) Is Insured a Patient? ☐ Yes ☐ No

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________________

Address: ______________________________ (Street / City / State / Zip Code)

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ (Last / First / MI) Is Insured a Patient? ☐ Yes ☐ No

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________________

Address: ______________________________ (Street / City / State / Zip Code)

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Insurance Plan Name and Address: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees it suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form.

______________________________ Date: __________ Relationship to Patient: __________

Signature of Patient, Parent or Guadian

______________________________ Date: __________ Relationship to Patient: __________

Signature of Guarantor of Payment/Responsible Party

VividDental
Greensboro

Established Patient - Dental and Medical History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: ___ /___ /___ Date of Birth: ___ /___ /___

Patient Name: _____ Prefer to be Called: _____

Employer Name: _____ Occupation: _____

Contact Information:

Address: _____

Email: _____

Cell Phone: _____

Can we email or text you to confirm appointments? YES / NO If yes, Email _____ Text _____ Both _____

Emergency Contact Name + Phone: _____

Physician / Specialist Name + Phone: _____

	No	Yes	Please Explain:
Any changes in insurance?			
Any change in health since last dental visit?			
Any upcoming or recent surgeries or hospitilizations since last dental visit?			
Any changes / concerns in dental health since last dental visit?			
Do you need to premedicate with an antibiotic before dental treatment?			
Are you taking any medications or supplements (prescriptions and/or non-prescription)?			
Are you allergic to any medications, anesthetics, metals or latex?			
Do you use any tobacco products?			
Do you use a CPAP machine?			
Do you wear a night guard?			
Females Only: Are you pregnant?			
Females Only: Are you taking birth control?			

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.

Patient, Parent or Guardian Signature: _____ Date: ___ /___ /___

Provider Signature: _____ Date: ___ /___ /___

VividDental
Greensboro

1126 N. Church St., Suite 102
Greensboro, NC 27401

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before siging this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____