Manchester RVA Dental

Patient Information
Please fill application out completely on both sides.

Patient Name:_____ Date:_____
Last First MI

___Male ___Female ___Married ___Single ___Child ___Other Nickname:_____
or preferred name

Social Security #: _____ - ____ - _____ Birth Date: _____/_____/_____
E-mail: _____ Home #:_____
Cell phone #:_____ Work:_____ (Ext.)_____
Preferred appt. times: ___Morning ___Afternoon ___Evening(Tue, Wed & Thurs) ___ Any time
___Tues ___Wed ___Thurs ___Fri ___Sat

Address: _____
Street Apartment #

_____
City State Zip Code

***We request your e-mail so we can send you e-mail reminders for your appointments so that confirming your appointment will only be a click away!
**We request your cell phone number so that we can contact you the day of your appointment should there be and emergency.

Health Information

Date of last dental visit:_____ Reason for this visit:_____

Do you or have you had any of the following? Please check only those that apply which may affect dentist visits:

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

_____
Pharmacy Telephone:

_____
Doctor Signature:

- Have you ever had any complications following dental treatment? ___Yes ___No
  Please explain if yes: _____
- Are you pre-medicated for dental treatment? ___Yes ___No.
  If yes what medication? _____
- Have you been admitted to a hospital or had emergency care during the past two years? ___Yes ___No
  If yes, please explain:: _____
- Are you 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: _____

Emergency Contact (name address and number): _____

_____

Information of person responsible of payment

The following is for: ___the patient's spouse ___the person responsible for payment ___self (information is in the front)

Name:_____ Birth Date: _____/_____/_____

Last First MI

___Male ___Female ___Married ___Single Social Security #: _____ - ____ - _____ Home #:_____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment information

The following is for: ___the patient ___the person responsible for payment.

Employer Name & phone #: _____ occupation: _____

Address: _____

Street City State Zip Code

Insurance information

Name of insured: _____ Birth Date: _____/_____/_____

Last First MI

Patient's relationship to insured: ___self ___spouse ___child ___other

Insurance name and phone number:_____

Id#:_____ group#:_____

Insurance address:_____

Street City State Zip Code

Consent for services

By signing this document, I certify that all of the information herein is true and accurate. I understand that the doctor is not responsible for complications that could occur due to my negligence of holding back vital information about my health. By signing, I make myself responsible of all financial charges incurred during my visits. I understand that here is a re-billing fee for accounts that are past due for more than 60 days of 1.5%. I grant the doctor and his faculty permission to call me to discuss my health and payment arrangements. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with all my treatments to the providers and staff of Smile32. I also authorize and direct payment of the dental benefits otherwise payable to me directly to Smile32.

I have read the above conditions of treatment and payment. By signing, I confirm that I understand and agree to the information written in this document.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Signature of person responsible for payment (if different from patient) Date

Referral Information

Whom may we thank for referring you to our practice?

____ Valpack ____ School ____Radio ____ Yellow Pages ____ Television

____ Newspaper ____ Hospital / Clinic ____ Found our business card at another business?

____ Dentist's Office: _____

Name of person referring you to our practice: _____

HIPAA CONSENT FORM
From the office of:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check any that you DO NOT want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.

__Work Cell	__Work Phone	__ Work Email	__Work Fax	__ Mail to Work
__ Personal Cell	__ Home Phone	__ Home Email	__ Home Fax	__Mail to Home
__Emerg. Contact	__Interpreter Contact			
__ **Any of the above**				

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

_____ **Full** access / **Partial** access _____

_____ **Full** access / **Partial** access _____

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

_____

Print Patient's Name: _____ **Date** _____

Print Legal Guardian's Name: _____ **Date** _____

Signature of Patient or Legal Guardian: _____ **Date** _____

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature_____ **Printed Name**_____ **Date** _____

Witnessed Staff Signature_____ **Printed Name**_____ **Date** _____

Manchester RVA Dental

Patient Name: _____ **Date:** _____

Patient Social Security No: _____ **Patient DOB:** _____

Current Medications

Medication Name	Dosage
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

Doctor Signature: _____ Date: _____

Manchester RVA Dental

RELEASE OF INFORMATION

I, _____, give Dr. Millan of Manchester RVA Dental my permission to release any and all records on the following patients:

_____

_____

_____

_____

_____

To be sent to:

_____

_____

_____

_____

Patient/ Parent/ Guardian Signature

_____

Date

_____

Relationship to the patient