Advanced Dental Concepts of Oakland

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name_____ Date_____ SSN_____
Address_____City_____State_____Zip_____
Date of Birth_____ Home phone#_____ Work phone#_____
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Either
Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
Email Address_____
You or your parent's employer_____Occupation_____
Business Address_____ City_____ State_____ Zip_____
Spouse's or parent's name_____ Workplace_____ Work phone#_____
If you are a student, name of school/college_____ City_____ State_____
Please let us know how your heard about our office? _____
Person to contact in case of emergency _____ Phone#_____

Responsible Party

Name of person responsible for this account?_____
Relationship to patient_____ Phone#_____
Address_____ City_____ State_____ Zip_____
Name of employer_____ Work phone#_____

Dental Insurance

Primary Carrier

Insurance Company_____
Address_____
City_____ State_____ Zip_____
Tel_____ Group #_____
Employer Name_____
Insured's Name_____
Insured's Date of Birth_____
Insured's SSN/ID#_____
Relationship to Patient_____

Secondary Carrier

Insurance Company_____
Address_____
City_____ State_____ Zip_____
Tel_____ Group #_____
Employer Name_____
Insured's Name_____
Insured's Date of Birth_____
Insured's SSN/ID#_____
Relationship to Patient_____

Dental History

Name: _____
Former Dentist_____
Reason for today's visit_____
Date of last exam_____ Date of last dental x-rays_____
Please check if any of the following conditions apply to you:

____ Bad Breath	____Grinding teeth	____Sensitivity to hot
____ Bleeding Gums	____loose teeth or broken fillings	____Sensitivity to sweets
____ Clicking or popping jaw	____Periodontal treatment	____Sensitivity when biting
____Food collection between teeth	____Sores or growths in your mouth	____Sensitivity to cold

Medical History **Advanced Dental Concepts of Oakland**

Physician Name_____ _____Phone_____
Date of last visit_____ Reason_____
Please list all medications you are currently taking: _____
Have you ever had an allergic or adverse reaction to any medication or substance? Yes No
If yes, list medication_____
Describe reaction_____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
Do you have a history of the following? Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Latex Sensitivity	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Allergies or Hives	Yes	No
Artificial Heart Valve	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Chemotherapy	Yes	No
Rheumatic Fever	Yes	No	Tumors/Cancer	Yes	No
Arthritis/Rheumatism	Yes	No	Hepatitis A or B	Yes	No
Cortisone Medication	Yes	No	Hepatitis C	Yes	No
Swollen Ankles	Yes	No	STD	Yes	No
Stroke	Yes	No	A.I.D.S	Yes	No
Diet (Special/Restricted	Yes	No	HIV Positive	Yes	No
Artificial Joints (Hip/Knee)	Yes	No	Cold Sores	Yes	No
Kidney Trouble	Yes	No	Blood Transfusion	Yes	No
Psychiatric/Psychological Care	Yes	No	Hemophilia	Yes	No
Ulcers	Yes	No	Sickle Cell Disease	Yes	No
Anorexia/Bulimia	Yes	No	Bruise Easily	Yes	No
Diabetes	Yes	No	Yellow Jaundice	Yes	No
Thyroid Problems	Yes	No	Epilepsy/Seizures	Yes	No
Glaucoma	Yes	No	Neurological Disorder	Yes	No
Contact Lenses	Yes	No	Fainting/Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous/Anxious	Yes	No
Emphysema	Yes	No	Do you take Bisphosphonates	Yes	No
Do you have a pacemaker	Yes	No	Do you have a stent, shunt or valve replacement	Yes	No
Are you currently taking any blood thinners	Yes	No			

Please list any artificial parts:

_____

_____

Authorization

I certify that I have read and understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Print Name _____
X_____ _____
Patient / Guardian Signature Date

Advanced Dental Concepts of Oakland

Consent For Use and Disclosure of Health Information (HIPAA)

Section A: Patient Giving Consent

Name of Patient:_____
(PRINT)

Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Right to Revoke: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

* If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.