# Annual Patient Information Updated(2021)

*****ALL PATIENTS MUST UPDATE THEIR INFORMATION YEARLY******

## PERSONAL INFORMATION

**THIS IS CURRENT INFORMATION ON FILE:**

Address: _____

City: _____ State: _____

Zip Code: _____

Driver's License /ID #: _____ State: _____

Phone: _____ Work: _____

Employer: _____

Email: _____

Address: _____

Marital Status: Single/ Married/ Divorced/ Widowed/ Separated

Employer Phone: _____

## PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____

Group/Company Name: _____

Insurance Member ID #: _____

## MEDICAL INSURANCE INFORMATION

Policy Holder: _____

Group/Company Name: _____

Insurance Member ID #: _____

## PRIMARY PHYSICIAN

Physician Name: _____ Phone: _____

Date of Last Visit: _____ Chief Complaint: _____

All medical history must be listed here to accommodate your visit correctly.

## MEDICAL HISTORY

Have you been tested for sleep apnea? □ Yes □ No

Have you been previously diagnosed with TMJ or TMJD? □ Yes □ No

Have you received previous treatment for TMJ or TMJD? □ Yes □ No

Are you allergic to Penicillin, Aspirin, or any other drug? □ Yes □ No Other: _____

Have you ever had a reaction to Novocain or Anesthesia? □ Yes □ No Date: _____

## CHILDREN ONLY

Has ever had pink eye? □ Yes □ No

History of Head Lice? □ Yes □ No Currently have Head Lice? □ Yes □ No Last Date of Treatment: _____

Are vaccinations up to date? □ Yes □ No

## WOMEN ONLY

For women only: Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Had exposure to HPV? □ Yes □ No

## MEDICATIONS

Please list **ALL** medications you are currently taking:

_____

_____

_____

Does the patient have any drug allergies? If Yes, list all.

_____

_____

_____

***Please continue on backside of this sheet****

***Have you ever used a bisphosphonate medication? Brand Names: Fosamax, Actonel, Atelvia, Didronel, Boniva.*** □ Yes □ No

Past or Present History of (Circle all that apply): □ **None Apply**

Accidental Injury to teeth/mouth
Blisters on Lips, Tongue, Mouth
Burning of Tongue
Chew on One Side of Mouth
Clench/Grind Teeth
Dental Fractures
Dry Mouth
Growths or Lesions in Mouth
Gums Swollen, Tender, Bleeding
Head, Neck, Jaw Pain
Lip or Cheek Biting
Loose Teeth or Broken Fillings
Mouth Breathing
Orthodontic Treatment
Nitrous Oxide
Periodontal Treatment
Sensitivity to Hot/Cold
Cold Sores

When was your last dental visit? _____ How often do you floss? _____

How often do you brush your teeth? _____ Are you in pain? _____

Is the damaged tooth a capped or previously restored tooth? _____

Have you had any of the following? (Circle all that Apply) or Check □ **None Apply**

AIDS/HIV
Anaphylaxis
ADD, ADHD
Autism
Anemia
Diabetes, Swelling of Feet/Ankles
Arthritis, Rheumatism, Cortisone Treatments
Artificial Heart Valves/Joints/ Mitral Valve Prolapse
Asthma, Shortness of Breath, Respiratory Disease
Atopic (Allergy Prone)
Anxiety, Depression
Heart Surgery, Pacemaker
Artificial Joints, Surgical Implant
Heart Attack
Back Problems, Spine Bifida
Blood Disease
Cancer/ Chemotherapy/ Radiation Treatment
Chemical Dependency, Tobacco Habit
Circulatory Problems, Blood Transfusion
Cortisone Treatments
Cholesterol
Epilepsy/Seizures
Cough, Coughing Blood
Food Allergies
Fainting
Headaches/Migraines
Glaucoma/Cataracts
Heart Murmur/Problems
Hemophilia/ Abnormal Bleeding
Herpes
Psychiatric Care/Bipolar
High Blood Pressure
Shingles, Skin Rash, Scarlet Fever
Stroke
Hepatitis (A B C)
Liver Disease/ Cirrhosis
Kidney Disease. Malfunction
Thyroid Disease, Malfunction, Tonsillitis
Material Allergies: Latex, Wool, Metal, Chemicals
Tuberculosis
Ulcer/Colitis
Venereal Disease

Are there any other health conditions you may have that are not listed? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

_____ _____

Signature Date

# Insurance Policy

Loftin Dental Center processes your claims as a courtesy. We will only process primary and secondary in network claims at this time. Assignment of benefits is selected to sure proper payment is made to our facility. If your plan does not allow the assignment of benefits option, you are solely responsible for any payments issued to you by your insurance provider for services rendered at our practice. Loftin Dental Center will allow 30 days from your check clearance date to submit payment to us. If no payment is made, you will be charged private pay fees. If your insurance company pays directly to the member, Loftin Dental Center will ask for full payment at time of treatment.

There is no guarantee of payment until your claim is reviewed by the insurance claims department. Loftin Dental Center will appeal denials at no charge. If an approval cannot be obtained, you will be solely responsible for any remaining balance for all services rendered.

This policy also extends to inactive insurance status at time of treatment. If you are due to terminate of your policy or employment, your insurance company may retro date all services at any time to reflect your termination date. This balance will be solely your responsibility.

Signing below states that you understand this policy and take full responsibility for finances.

_____ _____

Patient/Guardian Signature Date

# HIPPA Privacy Policy

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

Staff Member:_____

***Please continue on backside of this sheet****

# HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

***** We Will Not Disclose Any Information to Anyone Unless Listed on This Form*****

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Health information to be disclosed upon the request of the person name above. (**Check either A or B**):

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

☐ B. Disclose my health record, as above, **BUT DO NOT** disclose the following (check as appropriate):

- ☐ Mental Health Records
- ☐ Communicable Diseases (including HIV & AIDS)
- ☐ Alcohol/ Drug Abuse Treatment
- ☐ Other: _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

☐ An electronic record or access through an online portal

☐ Hard copy

☐ This authorization shall be effective until (check one)

☐ All past, present, and future periods

Date or event: _____unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Printed Patient Name: _____ Date: _____

Patient Signature: _____

Staff Member: _____