SOLTANIK DENTAL

CHART NUMBER_____

Patient's name_____
Last First Middle

Date of Birth____/_____/_____Social Security No. _____Sex ____Marital Status_____
MM DD YYYY

Address_____

Email _____Cellphone_____

Work Phone _____Home Phone _____

Employer_____Occupation_____

Responsible party _____Phone number_____

INSURANCE: Yes/No Insurance Company _____Name of subscriber_____

SS # of subscriber _____Date of Birth ____/____/_____Relationship with Patient_____

How were you referred to our office?_____

MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Are you in good health?	☐	☐	Respiratory problems, emphysema or bronchitis?
☐	☐	Have you ever had any serious illness or operations?	☐	☐	Kidney trouble?
☐	☐	Damaged or artificial heart valves; rheumatic fever?	☐	☐	Tuberculosis?
☐	☐	Heart or cardiovascular disease?	☐	☐	Sexually transmitted disease?
☐	☐	High blood pressure?	☐	☐	Epilepsy or other neurological disease?
☐	☐	Abnormal bleeding?	☐	☐	Cancer? Explain_____
☐	☐	Stroke?	☐	☐	Radiation treatments for cancer, tumors or growths?
☐	☐	Allergies to medicines or drugs?	☐	☐	Problems with previous dental treatments?
If yes, what?_____			☐	☐	Allergic to penicillin or codeine?
☐	☐	Sinus trouble?	☐	☐	Pregnant?
☐	☐	Asthma or hay fever?	☐	☐	Nursing?
☐	☐	Fainting spells or seizures?	☐	☐	Are you taking birth control pills?
☐	☐	Diabetes?	☐	☐	Do you grind your teeth at night?
☐	☐	Hepatitis, jaundice or liver disease?	☐	☐	Are you interested in whitening your teeth?
☐	☐	AIDS or HIV infections?	☐	☐	Do you have any other health concerns not
☐	☐	Thyroid problems?	mentioned?_____		

List any drugs you are presently taking?_____

_____

Name, phone number and address of your preferred pharmacy?_____

_____

IN CASE OF AN EMERGENCY

Please notify_____
Name Phone Relationship

REPRESENTATIONS

I understand that the information that I have given (including my medical history) is correct the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorized this office to verify my and my spouse's credit status prior to extending credit for treatment and the discretion of this office to use the service of one or more credit reporting services.

If this office accepts my insurance, I authorize payment directly to this office of any insurance benefits otherwise payable to me and I assign any and all the benefits to this office and I understand that I am responsible for payment for services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

If collection efforts are undertaken due to my failure to pay any and all the fees to this office, I agree to be responsible for any attorney's fees and costs incurred in connection with such collection efforts. I also understand that I will be charged interest at the rate of 1.5% per month on any outstanding balance (or the maximum allowed by law).

I consent to and authorize treatment recommended by the dental staff.

_____ _____

Patient Signature (Parent's signature if minor) Date

CHART NUMBER_____

HIPAA
PATIENT CONSENT FORM

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. 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 health care 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 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 uses 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 receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name – Patient or Representative

_____ ____/____/____

Signature Date

Witness:_____

Printed Name – Practice Representative

_____ ____/____/____

Signature Date