PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ____________________ Preferred name __________ Birth date__________

Name of responsible party ____________________ Social Security number: ____________________

Cell phone ______________ Email ____________________ Home/work phone __________

Mailing address ____________________ City ____________State _____ Zip ______

Employer ____________________ Occupation ____________________

Emergency contact ______________Relation__________ Phone number ______________

Whom may we thank for referring you to our office? ____________________

INSURANCE INFORMATION (only if you have not given to us over phone):

Dental Insurance Co.______________ Group number__________ Ins phone ______________

Have secondary insurance? ❑ yes ❑ no Covered by spouse's insurance? ❑ yes ❑ no

Spouse's/2nd dental ins company ______________ Group number __________ Ins phone __________

Spouse's name______________ Spouse's birthday __________ Social Security number __________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you been advised by your doctor to take anitbiotics before your dental visits? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:____________________

Are you taking any of the following? (**Please write name**)

- ❑ Aspirin
- ❑ Blood thinners
- ❑ Antibiotics or sulfa drugs
- ❑ Osteoporosis drugs
- ❑ Insulin or other diabetes drug
- ❑ High blood pressure medicine
- ❑ All other drugs or supplements/herbs not listed above:

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Women:

- ❑ May be pregnant: Expected delivery date:
- ❑ Breastfeeding
- ❑ Taking hormones or contraceptive

When was your last dental cleaning?

Have you have any **surgeries or problem** not listed above?____________________

What are your concerns for today's visit: ____________________

Is there anything we can do (or not do) to make your visit comfortable? ____________________

Patient / Responsible Party Signature:____________________ **Date** __________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Hosaka Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient / Responsible Party Signature:____ **Date** _____________

General Treatment Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Responsible Party Signature:____ **Date** _____________

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records as provided by the Georgia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient Name ____

Signature of Patient / Responsible Party ____ **Date** _____________

Dr. Hosaka and his staff believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation regardless of your insurance situation. Some patients have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_______ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

_______ ■ We are not able file for medical coverage with your insurance under any circumstances. We can only file your dental insurance. Our office does require payment in full for your portion at the time of service. We cannot accepts checks.

_______ ■ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is **impossible to give you a guaranteed quote at the time of service**. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**.

_______ ■ Often the insurance companies will use the term "usual and customary" or similar language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. Universal "usual and customary" fee schedules do not exist. The amount an insurance company reimburses for a procedure will vary with the company, the type, and the quality of a dental plan. **Because of this, even when the insurance company says that they will pay for 100% of a certain procedure, they may not pay for 100% of our office fee. They are saying they will pay for 100% of a fee that THEY have decided as being as being appropriate for that particular dental plan.** Our fee schedule is the same for everyone. The only time there is a variation in charges is when there exists a contract between an insurance company and us to provide care at a discount in exchange for qualifying as a "participating provider-dentist".

_______ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Hosaka Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that **the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract.** Ultimately, you are responsible for all charges incurred in our office.

_______ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a $50/hour cancellation fee (emergencies are an exception).

I agree with the above conditions.

Print Patient Name ____

Signature of Patient / Responsible Party ______________________________________ **Date** ______________