DENTAL PATIENT INFORMATION			
Last Name	**First Name**	**Middle Initial**	**Email for Patient Portal**
Street Address	**Mailing Address**	**City, State**	**Zip Code**
Home Phone	**Work Phone**	**Cell Phone**	**Best way to contact you** ☐Home ☐Work ☐Cell
Date of Birth (mm/dd/yyyy)	**Sex at Birth** ☐ Male ☐ Female	**Marital Status:** ☐Married ☐Single ☐ Divorced ☐Separated ☐Widowed	
Social Security Number	**Employer/School Name and Address** (City, State)		**Zip Code**
Employment Status ☐Self Employed ☐Full Time ☐Part Time ☐Unemployed ☐Retired		**Student Status** ☐Full Time ☐Part Time ☐Not a Student	
Race(s) ☐ Native American/Alaska Native ☐ Decline ☐White ☐ African American ☐Pacific Islander ☐Asian		**Ethnicity** ☐Decline ☐Hispanic ☐Non-Hispanic	**Language** ☐English Other:
Veteran ☐Yes ☐No	**Migrant** ☐Yes ☐No	**Homeless** ☐Yes ☐No	**Deemed disabled by SSA** ☐Yes ☐No
RESPONSIBLE PARTY **Legal guardian if a minor AND/OR person to be billed if other than the above patient.**			
Last Name	**First Name**	**Date of Birth** (mm/dd/yyyy)	
Address (if different from patient)	**City**	**State**	**Zip Code**
Primary Phone		**Relationship to Patient**	

CONSENT FOR TREATMENT/CARE

I consent to treatment and care by Highland Medical Center (HMC) health care providers. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I am aware that the practice of medicine is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

FINANCIAL:

Due to the increased cost of mailing statements, and to help keep our fees as low as possible, we find it necessary to expect our patients to pay their co-pay/coinsurance/deductible or non-insurance expenses at the time of service. Bills over 120 days past due may be turned over to a collection agency. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits for professional services rendered to Highland Medical Center, Inc.

_____

PRINTED PATIENT NAME

_____ DATE: _____

PATIENT **SIGNATURE** (or Authorized Representative)

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Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. HMC can receive and share health information with other health professionals and hospitals who are treating you.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

By completing below, I am acknowledging that I have read the Highland Medical Center's Privacy Notice, have been offered a copy, and had an opportunity to ask question.

Printed Name of Patient: _____

Date of Birth of Patient: _____

Printed Name of Guardian, if appropriate: _____

Signature of Patient or Guardian:_____Date:_____

RELEASE OF INFORMATION

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Highland Medical Center, Inc. to release any information required in the course of my examination or treatment to the following designated person(s):

Emergency Contact:_____Relationship & Phone #:_____

Name:_____Relationship & Phone #:_____

Name:_____Relationship & Phone #:_____

ADVANCE DIRECTIVE (Living Will/ Medical Power of Attorney)

An Advance Directive is a legal document that states your wishes regarding medical treatment in the event that you are unable to communicate these decisions. *It is very important that all of your healthcare providers have a current copy of these documents.*

____ I HAVE completed an Advance Directive. **Copy provided to HMC? Yes / No**

____ I HAVE NOT completed an Advance Directive. I would like more information. Yes / No

HMC DENTAL CARE

Patient Name_____DOB:_____DATE:_____

CIRCLE

1. Are you having pain or discomfort at this time?..... Yes No
2. Do you feel very nervous about having dental treatment?.....Yes No
3. Have you ever had a bad experience in the dental office?..... Yes No
4. Have you been a patient in the hospital during the past two years?.....Yes No
5. Have you been under the care of a medical doctor during the past two years?.....Yes No
   Physician's Name _____
   Address_____ Phone #_____
6. Are you now taking medication, drugs, or pills?..... Yes No
   If yes, please list: _____
7. Are you allergic to or have you reacted adversely to any of the following? Please check all that apply

☐ Latex	☐ Erythromycin	☐ Other Antibiotics	☐ Prilocaine (Citanest)
☐ Nitrous Oxide	☐ Tetracycline	☐ Aspirin	☐ Xylocaine (Lidocaine)
	☐ Penicillin	☐ Ibuprofen (Advil)	☐ Mepivicaine
	☐ Clindamycin	☐ Tylenol (Acetaminophen)	☐ Articaine (Septocaine)

8. Are you aware of being allergic to any other medications or substances?..... Yes No
   If yes, please list: _____
9. When you walk up stairs or take a walk do you ever have to stop because of pain in your chest, shortness of breath or because you are Very tired?..... Yes No
10. Are you taking blood thinners?..... Yes No
11. Do you ever wake up from sleep short of breath?..... Yes No
12. Has your medical doctor ever said you have cancer or a tumor?..... Yes No
13. Do you have any disease, condition or problem not listed?..... Yes No
14. Do you have high blood pressure? .....Yes No
    If yes, is your blood pressure under control with medication?..... Yes No
15. Are you taking any of the following? ☐ Fosamax ☐ Reclast ☐ Boniva ☐ Cortisone

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

** **WARNING: Use of antibiotics can counteract effectiveness of birth control pills.**

Check any of the following which you have had or have at present:

☐ AIDS-HIV	☐ Congenital Heart Problems	☐ Artificial Heart Valve	☐ Behavioral Health Treatment
☐ Allergies/Hives	☐ Cough	☐ Tachycardia	☐ Radiation/Cobalt Treatment
☐ Anemia	☐ Diabetes	☐ Hemophilia/Other	☐ Rheumatic Fever
☐ Anginal Chest Pain	☐ Easy Bruising	☐ Bleeding Disorder	☐ Rheumatism
☐ Arthritis	☐ Emphysema/COPD	☐ Hepatitis A, B, or C	☐ Scarlet Fever
☐ Artificial Joint (hip, knee)	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Sexually Transmitted Infection
☐ Asthma	☐ Fainting/Dizzy Spells	☐ Jaundice	☐ Sickle Cell Disease
☐ Bleeding Disorder	☐ Glaucoma	☐ Kidney Trouble	☐ Sinus Trouble
☐ Blood Transfusion	☐ Heart Disease	☐ Liver Disease	☐ Stroke
☐ Breathing Difficulty	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Substance Use Disorder
☐ Cancer	☐ Heart Pacemaker	☐ Nervousness	☐ Thyroid Disease
☐ Chemotherapy	☐ Heart Surgery	☐ Pain in Jaw	☐ Tuberculosis
			☐ Ulcers

I 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 changes in my health or medication.

Patient/Guardian Signature_____ ***Date*** _____

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