Bliss Dental
Family and Cosmetic Dentistry

PATIENT INFORMATION

Date_____

Patient Name (First)_____ (Last)_____

Birthdate_____ Age_____ Sex ☐ M ☐ F SS Number_____

Street Address_____

City_____ State_____ Zip code_____

Parent/Guardian address (if different) _____

Phone #_____ Cell #_____

Email _____

How were you referred to or find us? _____

EMERGENCY CONTACT

Name_____ Relationship_____

Phone #_____ Cell #_____

INSURANCE INFORMATION

Insurance Company_____ Phone #_____

ID #_____ Group #_____

Subscriber Name_____

Subscriber Birthdate_____ SS Number_____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named Insurance Company and assign directly to **Bliss Dental** all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named medical facility may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient with the above named medical facility.

_____
Please Print Name of Signature of Patient, Parent, Guardian or or Personal Representative

_____
Signature of Patient, Parent, Guardian
Personal Representative

_____
Relationship to Patient

_____
Date

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HEALTH HISTORY

Patient (printed) name (First)_____ (Last)_____ DOB: _____

Please check "yes or no" to indicate if you have, or have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding Abnormally	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet/Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck/Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesion	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, Persistent, Bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, severe	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Taking Birth Control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Physician's Name and Phone Number (Name)_____ (Phone)_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Y ☐ N

MEDICATIONS

List any medications you are currently taking.

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

ALLERGIES

Do you have any of the allergies listed below?

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Barbiturates (sleeping pills)	☐	☐	Local Anesthetic
			☐	☐	Iodine
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Other_____			

Patient signature_____ **Date**_____

Doctors Signature_____ **Date**_____

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INFORMED CONSENT FORM

1. Drugs and Medications:

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction)..... (Initials _____)

2. Changes In Treatment Plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed ..... (Initials _____)

3. Removal Of Teeth:

Alternatives to removal will be explained to me (root canal therapy, crowns, dentures and periodontal surgery, etc.) and I will have the choice of the best procedure for me. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility..... (Initials _____)

4. Crowns and Bridges:

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown/bridge (including shape, fit, size, color) will be before cementation ..... (Initials _____)

5. Endodontic Treatment (Root Canal Therapy):

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)..... (Initials _____)

6. Periodontal Loss (Tissue & Bone):

I understand that periodontal disease is a serious condition, causing gum and bone infection or loss and that it can lead to loss of my teeth. Alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition..... (Initials _____)

7. X-Rays:

I understand x-rays are needed for proper diagnosis and treatment..... (Initials _____)

8. Dentures, Complete or Partials:

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems with wearing these appliances has been explained to me, including, looseness, soreness and possible breakage. I realize the final opportunity to make changes to my new dentures (including, shape, fit, size, placement & color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for these procedures are not included in the initial denture fees. I understand wearing dentures is difficult & there are common problems such as sore spots, altered speech & difficulty eating. Immediate dentures (placement of dentures immediately after extractions) may be painful, will require considerable adjustments & several relines and a permanent reline will be needed later; this is NOT included in the denture fee. It is important to make all necessary impression, try-in & delivery appointments, failure to make these appointments can result in poorly fitting dentures and the need to remake them, resulting in additional charges..... (Initials _____)

9. Fillings:

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common after effect of a newly place filling ..... (Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____, _____

Printed Name of Patient (First , Last) Birthdate

_____

Patient Signature Date

_____

Signature of Parent/Guardian if patient is a minor

_____

Doctor's Signature Date

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GENERAL CONSENT

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1.) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2.) I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee.

3.) In general terms, the dental procedure(s) can include but not limited to:

A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
B. Application of resin "sealants" to the grooves of the teeth.
C. Treatment of diseased, or injured teeth with dental restorations (fillings).
D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections

4.) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5.) I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6.) I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

(First) (Last)
PATIENT NAME

DATE OF BIRTH

PARENT/GUARDIAN IF PATIENT IS A MINOR

RELATIONSHIP TO PATIENT

SIGNATURE

DATE

Bliss Dental
Family and Cosmetic Dentistry

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 48 hours' notice.
- Treatment plans may change, and I will be responsible for the work actually done.
- I agree to let this office run a credit report. If no, then all fees are due at time of service.
  - ☐ Yes
  - ☐ No

_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

PARENT/GUARDIAN IF PATIENT IS A MINOR RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

Notice of Privacy Practices

Revision, September 2017

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIVrelated information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable costbased fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. I f you request this accounting more than once in a 12month period, we may charge you a reasonable, costbased fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Bliss Dental
Family and Cosmetic Dentistry

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

☐ I have received the **"Notice of Privacy Practices"** and have been provided an opportunity to review it.

Patient Name (First)_____ (Last)_____ Birthdate_____

Parent/Guardian_____

Signature_____ Date_____