Welcome to Siebenthaler Dental Center

Please take a few minutes to fill out this form as completely as you can.
If you have any questions, we'll be glad to help you.

PATIENT INFORMATION

Name_____

Last First MI (Preferred/ Nick Name)

Gender: [ ] M [ ] F Marital Status: S / M / D / W DOB: _____

Email: _____ SS#_____

Address:

Street_____ Apt # _____

City_____ State_____ Zip_____

Phone:

Home ( )_____ Work ( ) _____ Wireless ( )_____

Person responsible for account: [ ] Self [ ] Other:_____

If other; SS#:_____

How did you hear about us? [ ] From another patient [ ] Social Media [ ] Website [ ] Other

_____

(If someone referred you here, please write down his/her name so we can send a thank you.)

INSURANCE POLICY 1

[ ] Insurance [ ] Self Pay [ ] Dental Care Savings Club (non-insured patients, ask about our in-house program)

Please present insurance card/ information to receptionist

*Insurance will be verified by phone or internet.

INSURANCE POLICY 2 (If available)

[ ] None

Please present insurance card/ information to receptionist

*Insurance will be verified by phone or internet.

NOTICE OF PRIVACY POLICIES (HIPAA)

I have been given the opportunity to read and consider the contents of the Notice of Privacy Practices (HIPAA). I understand that I am giving my permission to the use and disclosure of my protected health information (PHI) in order to carry out treatment, payment activities and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Siebenthaler Dental Center** may decline to provide treatment to me.

This office is paperless and digital photos will be taken for medical identification purposes only.

**** Signature's will be collected electronically at receptionist desk once information is entered into chart****

Emergency Contact_____ Phone_____ Relationship_____

A Contact must be listed for every patient. This contact will be allowed to receive all PHI for the patient listed.

List all medications the patient is taking:

[ ] None_____

_____

_____

_____

_____

List any medications the patient is allergic to:_____

_____

List any medical conditions for the patient:: *For example*: anemia, asthma, bleeding problems, cancer, diabetes, epilepsy, glaucoma, heart trouble, hepatitis, herpes, high/low blood pressure, HIV+/Aids, kidney disease, liver disease, psychiatric treatment.

[ ] None_____

_____

*Has the patient had a joint replacement in the past year? Y / N

If Yes: Joint Replaced: _____ Date: _____

Joint Replaced: _____ Date: _____

Is the patient currently on a blood thinner? Y / N

If Yes: Medication: _____ Daily Dose: _____

*Is the patient currently pregnant? Y / N If Yes: Due Date: _____

Does the patient currently use a Continuous positive airway pressure (CPAP) machine Y / N

***** PLEASE be advised any patient under the age of 18 WILL need verbal permission to be treated at every appointment******

ALL signatures will be collected electronically after receptionist has entered into your chart.