Farni & Farni Family Dentistry L.L.P

PATIENT INFORMATION DATE:_____

Name Name: _____ _____ _____ Social:_____

Last Name First Name Middle Initial

Patient Lives With : Self Other _____

Home Address: _____ _____ _____ _____

Street City State Zip Code

Mailing Address: _____ _____ _____ _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

D.O.B._____ Sex F M Marital Status: S M D W

In Case of Emergency who should be notified?_____ Phone _____

RESPONSIBLE PARTY:_____

Relationship to patient:_____

Address (if different from patients) _____ _____ _____ _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

INSURANCE OVERVIEW

PRIMARY DENTAL:_____ EMPLOYER:_____

Subscriber Name:_____ SSN:_____ DOB:_____

Relationship to Patient: (Circle One) Self Spouse Child Other:_____

SECONDARY DENTAL:_____ EMPLOYER:_____

Subscriber Name:_____ SSN:_____ DOB:_____

Relationship to Patient: (Circle One) Self Spouse Child Other:_____

DENTAL HISTORY

Former Dentist:_____ Phone Number:_____

Patient Name:_____ DOB:_____

Dental History:

Reason for todays visit ☐ Tooth Ache ☐ Check Up Other :_____

Have you ever visited a dental specialist? ☐ Oral Surgeon ☐ Orthodontist ☐ Endodontist ☐ Periodontist

Specialist Name:_____

Allergies:

Are you allergic to or have you had any reactions to the following:

	Yes	No		Yes	No
Local anesthetics	___	___	Latex Rubber	___	___
Penicillin	___	___	Aspirin ___	___	
Sulfa drugs	___	___	Any metals	___	___
Codeine	___	___	Iodine	___	___
Sedatives	___	___	Other:_____		

Medical History:

Have you ever had any serious illnesses or operations?_____ If yes, describe:_____

_____

Have you ever had a blood transfusion?_____ If yes, give approximate dates:_____

Women Only: Are you pregnant or think you may be pregnant?_____

Are you taking any medications? If yes, please list_____

_____

Do you use tobacco products?_____ If yes, list type & quantity_____

Do you have or have you had any of the following?

☐ AIDS/HIV
☐ ANEMIA
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVES
☐ ARTIFICIAL JOINTS
☐ BACK PROBLEMS
☐ ASTHMA
☐ BLOOD DISEASE
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CHEMOTHERAPY
☐ CHOLESTEROL
☐ CIRCULATORY PROBLEMS
☐ CORTISONE TREATMENTS
☐ CONGENTIAL HEART DISEASE
☐ PRESISTANT COUGH
☐ HEARING IMPAIRED
☐ DIABETES
☐ ULCER

☐ EPILEPSY
☐ EMPHYSEMA
☐ FAINTING
☐ GLAUCOMA
☐ HEADACHES
☐ HEART MURMUR
☐ HEART PROBLEMS
☐ HEMOPHILIA
☐ HEPATITIS
☐ HERPES
☐ HIGH BLOOD PRESSURE
☐ JAW PAIN
☐ JAUNDICE
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ MENTAL DISABILITY:
_____
☐ MITRAL VALVE PROLASPSE

☐ NERVOUS PROBLEMS
☐ PACEMAKER
☐ PINS, SCREWS, AND PLATES
☐ PSYCHIATRIC CARE
☐ RADIATION TREATMENT
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ SHORTNESS OF BREATH
☐ SKIN RASH
☐ STROKE
☐ SWOLLEN NECK GLANDS
☐ SWELLING OF FEET
☐ THYROID PROBLEMS
☐ TONSILLITIS
☐ TUBERCULOIS
☐ TUMOR OF THE HEAD OR NECK
☐ VENEREAL DISEASE
☐ UNEXPLAINED WEIGHT LOSS

Any other medical conditions not listed:_____

Have you been advised by your physician to take pre-medications prior to any dental treatment?_____

Signature:_____ **Date:**_____

Farni & Farni Family Dentistry L.L.P

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCOLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it completely and carefully before signing this Consent.

We reserve the right to change our privacy practices as they are described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. **I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations only.**

*_____

Please Print Patient's Name

*

_____

Patient's Signature/Guardian of Minor Date

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

REVOCATION OF CONSENT: Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. **I understand that my revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

*_____

Please Print Patient's Name Date

*_____

AUTHORIZATION AND RELEASE

I understand that it is my responsibility to inform the dental office of any changes in my medical status or insurance coverage. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. Our practice no longer does amalgam (metal fillings). We now only use composite or tooth colored fillings. I understand that Farni and Farni Dentistry is a Non Amalgam practice and I may be responsible for the difference between amalgam and composite fillings. I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other State. I also give Farni and Farni Dentistry, its employees and/or agents “express prior consent” to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, or payment.

Patient Signature:_____Date_____