PATIENT INFORMATION AND HIPPA CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose health information about you. The Notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a notice of privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures with then cease.
- The practice may condition receipt of treatment upon the execution of this consent.
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This Consent was signed by: X_____ **X**_____ **Date** ___/___/____

Patient Name- **Printed** Patient Name- **Signature**

Address _____ City _____

State _____ Zip _____ Phone _____

Age _____ Date of Birth _____ Gender: M F Other: _____

How did you hear about us? _____

Emergency Contact _____ Phone No. _____

Dentist Name _____

Are you covered by Dental insurance? Yes ☐ No ☐

Insured Person Name _____

S.S. _____ Date of Birth _____

Employee Name _____

Address _____

Dental Company Name _____ Policy No. _____

Signature: _____ **Date:** _____

Dental History

1. Is this a Replacement Denture? ..... YES NO
   Year present denture placed? Upper _____ Lower _____
2. Have you ever had serious trouble during previous dental treatment? ..... YES NO
3. Have you ever had sores on the lips or mouth that are slow the heal? ..... YES NO
4. Do you have difficulty in opening your mouth wide? YES NO
5. Have you ever had injuries to your face or jaw?.....YES NO
6. Do you have TMJ disorder? ..... YES NO
7. A gagging problem? ..... YES NO

Medical History

(Do you have an of the following?)

A. Rheumatic Fever ..... YES NO
B. High or Low Blood Pressure ..... YES NO
C. Cancer or Tumor ..... YES NO
D. Epilepsy ..... YES NO
E. Excessive Bleeding ..... YES NO
F. Heart Trouble ..... YES NO
G. Allergies ..... YES NO
H. Diabetes ..... YES NO
I. Infectious Disease ..... YES NO
J. HIV ..... YES NO

⬇ DO NOT WRITE BELOW THIS LINE (*OFFICE USE ONLY*) ⬇

RECORD OF TREATMENT AND PROCEDURES

RELINE: UPPER LOWER SOFT/HARD ☐ PREMIER ECONOMY **Signature:** _____

DENTURE: UPPER LOWER IMMEDIATE ☐ PREMIER HIGH-QUALITY **Date:** _____

PARTIAL: UPPER LOWER FLEXI/METAL ☐ PREMIER DELUXE

Shade: _____ **Size:** _____ **Arrangement #:** _____

Procedure Code: _____

Procedure Code: _____