PARKLANE FAMILY DENTAL
ACQUAINTANCE INFORMATION AND MEDICAL HISTORY

PATIENT INFORMATION

Date_____

Patient_____ Prefer to be called [ ]

Address_____ E-mail Address [ ]

City_____ State_____ Zip_____

Home_____ Cell_____ Work_____

Sex ☐ M ☐ F Age_____ Birthday_____ ☐ Single ☐ Married ☐ Divorced

Social Security No._____

Employed by [ ] Occupation_____

Business Address_____ Phone_____

In case of emergency, whom should be notified?_____ Phone_____

Have we treated any of your immediate family? [ ] Their Name_____

Closest relative not living with you_____ Phone_____

Whom may we thank for referring you to us? [ ]

Person responsible for account? (If Different than Patient) ☐ Spouse ☐ Parent ☐ Other_____

Name_____

Address_____ Phone_____

City_____ State_____ Zip_____

Social Security No._____ Birthday_____

Employed by [ ] Occupation_____

Business Address_____ Phone_____

Spouse's Information (If Not Above)

Name_____

Social Security No._____ Birthday_____

Employed by Occupation_____

Business Address_____ Phone_____

INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No

Employee/Subscriber Name_____

Name of Dental Insurance Company [ ]

ID No._____ Birthday_____

Do you have a second Insurance company? ☐ Yes ☐ No

Employee/Subscriber Name_____

Name of Insurance Company [ ]

ID No._____ Birthday_____

Physician's Name_____ Date of Last Physical_____

MEDICAL HISTORY

Have you ever had any of the following?

YES ☐ NO ☐	Heart Problems	YES ☐ NO ☐	Epilepsy
YES ☐ NO ☐	High Blood Pressure	YES ☐ NO ☐	Hepatitis, Jaundice or Liver Disease
YES ☐ NO ☐	Stroke	YES ☐ NO ☐	Cancer / Treatement
YES ☐ NO ☐	Rheumatic Fever	YES ☐ NO ☐	Psychiatric Care
YES ☐ NO ☐	Respiratory Disease	YES ☐ NO ☐	Allergies to Local Anesthetics
YES ☐ NO ☐	Nervous Problems	YES ☐ NO ☐	Arthritis
YES ☐ NO ☐	Diabetes	YES ☐ NO ☐	Sinus Problems
YES ☐ NO ☐	HIV Positive / AIDS	YES ☐ NO ☐	Other_____

Are you allergic to any medicine? ☐ Yes ☐ No [ ]

Are you taking any medicine at this time? ☐ Yes ☐ No _____

Do you suspect you are pregnant? (women) ☐ Yes ☐ No _____

Do you have any diseases, condition, or problem not listed? ☐ Yes ☐ No _____

Has there been any change in your health in the past year? ☐ Yes ☐ No _____

I understand that where appropriate, Credit Bureau reports may be obtained.

Date_____ Signature_____

Signature of Person Responsible for Account

PARKLANE FAMILY DENTAL
INFORMED CONSENT FOR TREATMENT, USE AND DISCLOSURE OF HEALTH INFORMATION

INITIAL DIAGNOSTIC PROCEDURES: In order to help formulate treatment recommendation, the following diagnostic procedures may be performed: (1) a medical and dental history, (2) discussion of your dental problems, concerns and desires, (3) x-rays, (4) plaster casts of the mouth and teeth (5) if additional diagnostic procedures or consultations are indicated, they will be discussed with you.

TREATMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where supporting structures are compromised, recommendations can be made only after consultation with specialists. We will also inform you of the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time. You are welcome at any time to seek a second opinion.

REFERRAL TO OTHER SPECIALISTS: Dental restorative and prosthodontic treatment often requires concurrent treatment with other specialties such as: Periodontics, Endodontics, Anesthesiolgy, Orthodontics, Oral Surgery, Physician (M.D.)

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as Novacaine and Zylocaine). In addition, sedative and pain medications can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Some sedative or pain medication may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation with another person to and from the office. Nitrous Oxide Sedation is used if needed, as well.

MEDICAL HISTORY: I understand the medical and dental history 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. I will notify Parklane Family Dental Clinic of any change in my health or medication prior to treatment.

TREATMENT: Upon such diagnosis, I authorize Parklane Family Dental Clinic or the designated staff person to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

INFORMED CONSENT AND AUTHORIZATION: I certify that I have read and understand this Informed Consent, which outlines the general treatment consideration as well as the potential problems and complication of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document and discussed with me. I understand that during and following the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials or care, if it is felt this is for my best interest. In addition, I consent that photographs and/or videos of the procedures may be shown for teaching and education purposes. This consent is in force indefinitely unless revoked by me in writing.

CONTACTS: I also give my permission to have Parklane Family Dental Clinic personally contact me and remind me of needed appointments through the U.S. mail, (postcard or letters), e-mail, and /or voice messages at home or work.

PAYMENT: Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorize payment directly to Parklane Family Dental Clinic of any insurance benefits otherwise payable to me. I authorize the release of any information relating to dental claims.

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 whether 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 carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice, including any revision of our Notice, at any time.

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

SIGNATURE_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____

Relationship to Patient_____

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