PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name _____ Preferred Name _____ Date of Birth_____

If minor, parents names _____ Home Phone _____ Work Phone _____

Mailing Address _____ City _____State _____ Zip _____

Email _____ Sex M F Reason for Today's Visit _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Emergency Contact Phone _____

Spouse's Name _____ Spouse's Employer _____ ❑ Single

Whom may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Spouse Social Security number _____

MEDICAL HEALTH HISTORY

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

	Yes	No
Cancer or tumor.	❑	❑
Heart ailment or angina	❑	❑
Heart murmur, mitral valve prolapse, heart defect	❑	❑
Rheumatic fever or rheumatic heart disease	❑	❑
Artificial joint or valve	❑	❑
High or low blood pressure	❑	❑
Pacemaker	❑	❑
Tuberculosis or other lung problems	❑	❑
Kidney disease	❑	❑
Hepatitis or other liver disease	❑	❑
Alcoholism	❑	❑
Blood transfusion	❑	❑
Diabetes	❑	❑
Neurologic condition	❑	❑
Epilepsy, seizures, or fainting spells	❑	❑
Emotional condition	❑	❑
Arthritis	❑	❑
Herpes or cold sores	❑	❑
AIDS or HIV positive	❑	❑
Migraine headaches or frequent headaches	❑	❑
Anemia or blood disorders	❑	❑
Abnormal bleeding after surgery or trauma	❑	❑
Hayfever or sinus trouble	❑	❑
Allergies or hives	❑	❑
Asthma	❑	❑
Do you smoke or use chewing tobacco?	❑	❑

Are you allergic to or have you reacted adversely to any of the following?

	Yes	No
Latex materials	❑	❑
Penicillin or other antibiotic	❑	❑
Local anesthetics ("Novocaine")	❑	❑
Codeine or other narcotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Aspirin	❑	❑

Other:_____

Are you taking any of the following?

Aspirin	❑	❑
Anticoagulants (blood thinners)	❑	❑
Antibiotics or sulfa drugs	❑	❑
High blood pressure medicine	❑	❑
Antidepressants or tranquilizers	❑	❑
Insulin, Orinase, or other diabetes drug	❑	❑
Nitroglycerin	❑	❑
Cortisone or other steroids	❑	❑
Osteoporosis (bone density) medicine	❑	❑

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Please list your medications:_____

_____

Name of your physician:_____Physician Phone Number:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Signature of patient (or parent):_____ **Date:** _____

DENTAL HEALTH HISTORY

	Yes	No
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive?	❑	❑
Does food or floss catch between your teeth?	❑	❑
Is your mouth dry?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑
Is your home water supply fluoridated?	❑	❑
Do you drink bottled or filtered water?	❑	❑
Are you currently experiencing dental pain?	❑	❑

	Yes	No
Do you have earaches or neck pains?	❑	❑
Do you have any jaw discomfort?	❑	❑
Do you brux or grind your teeth?	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑
Do you wear dentures or partials?	❑	❑
Do you participate in active recreational activities?	❑	❑
Have you had a serious injury to your head or mouth?	❑	❑

Other:_____

Date of your last dental exam if performed in another office:

Please add anything else you would like us to know about:_____

DR. RENAKER'S NOTES

FINANCIAL ACKNOWLEDGEMENT AND RELEASE FOR DR. JESSICA RENAKER

We provide services for our patients with the understanding that they are responsible for all charges incurred for treatment. As a courtesy, we will prepare claim forms to assist you in obtaining maximum benefits available. As a courtesty, Dr. Renaker gives our patients **ESTIMATES** based on the information given to us by your insurance company. We treat every patient based on individual need, not what an insurance company deems necessary. Dr. Renaker has a relationship with **YOU**, our patient and not with your insurance company. Your benefits are an arrangement between your employer and insurance company. If your insurance ever "downgrades" your coverage for certain procedures, or pays less because of out of network, we have no control over what your insurance pays us for your treatment. If there is a remaining balance after your insurance settles, the balance is **YOUR** responsibility.

I give Dr. Renaker and staff members my consent for dental treatment. I understand that if my account is not paid in full within 60 days of the statement received, I agree to reimburse Jessica H. Renaker, DMD, PLLC the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

_____

Patient or Guardian Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this HIPAA acknowledgement.

I have reviewed a copy of Dr. Renaker's notice of privacy practices.

_____

Patient or Guardian Signature **Date**

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS TO EXTERNAL PARTIES

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____ Relationship to Patient:_____

I authorize to disclose the following information:

- ❑ All treatment information
- ❑ Information specifically related to these dates: Start Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Jessica H. Renaker, DMD, PLLC in writing.

Signature of Patient (or Patient Representative) _____ Date: _____

Printed Name of Patient (or Patient Representative) _____

APPOINTMENT AGREEMENT FOR DR. RENAKER

Welcome to our practice. We are honored that you have selected us for all of your dental needs. As a patient, we want to share with you that we are 100% committed to providing timely and quality service to all our patients. Because missed appointments increase the cost of healthcare for everyone, we appreciate your understanding in keeping your scheduled appointments.

The doctor and hygienist reserve a specific amount of time for every paient. We never double book your appointment so that your reservation is always honored by our staff. If you need to reschedule your dental appointment, we require a 24 hour courtesy notice so that we may provide the opportunity to a patient who is on our waiting list for an earlier appointment. **If 24 hours courtesy notice is not given, there is a $50 failed appointment fee that will be added to your account.** We will be happy to put you back onto our schedule after your account balance has been settled.

I understand and will honor the practice's appointment agreement.

_____

Patient or Guardian Signature **Date**