New Patient Form

Date:

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Charlton Dental Associates

Patient Information

Last Name _____ First Name _____ Middle Name _____

☐ Male ☐ Female SS # _____ Date Of Birth _____ Nickname _____

Street Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Email _____

Employer (Parent's Employer, if Child) _____ Position _____

Employer's Address _____ Work # _____

Name of Spouse _____ Spouse's Employer _____

Physician _____ Physician Phone # _____

School name _____ City _____ State _____

Who may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT: ☐ Patient ☐ Spouse/Parent ☐ Guardian

(If different from patient info) Last Name _____ First Name _____

Street Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

EMERGENCY CONTACT INFORMATION:

Name _____ Phone # _____

(Nearest relative not living with you) Name _____ Phone # _____

Dental Insurance Information

Name on Card _____ Birth Date _____

Insurance Company _____ Group # _____

Agreement or SS # _____ Relationship to Patient _____

Amount of Deductible _____ Maximum Annual Benefit _____ (Please give insurance card to receptionist)

SECONDARY DENTAL INSURANCE INTORMATION

Name on Card _____ Birth Date _____

Insurance Company _____ Group # _____

Agreement or SS # _____ Relationship to Patient _____

Amount of Deductible _____ Maximum Annual Benefit _____ (Please give insurance card to receptionist)

I understand that (regardless of my insurance status), I am responsible for the payment of my account for professional services rendered. I hereby certify that I have read this form and answered all above questions to the best of my knowledge. I certify this information to be true and correct. I will notify this office of any changes to the above information and of any changes to my (patient's) health status.

SIGNATURE _____ Date _____

FINANCIAL ARRANGEMENT

If you have any questions concerning financial arrangements please ask for assistance. Please be aware that any unpaid balance will be subject to a 1.5% late fee each billing cycle until balance is cleared. For your convenience, we offer the following methods of payment.

We accept the following: Cash, personal checks, money orders or credit cards: Visa, Discover, Master Card.

Medical History Form

Date:

Charlton Dental Associates

Medical Information

1. Are you currently under the care of a Physician? Yes No

Name _____ Phone # _____

Reason: _____

2. What prescription or non-prescription liquids, tablets, or pills do you take? (if any)

Medication Name	mg/dose	times/day	Medication Name	mg/dose	times/day

3. Are you sensitive or allergic to any of the following? (check all that apply)

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Anesthetics ☐ Latex

Please explain _____

4. Have you ever bled excessively after a cut, wound or surgery? ☐ Yes ☐ No

If **Yes**, Please explain _____

5. Are you subject to fainting, dizziness, nervous disorders or epilepsy? ☐ Yes ☐ No

If **Yes**, Please explain _____

6. Have you ever had breathing difficulty, asthma, chronic cough, pneumonia or lungdisorders?

☐ Yes ☐ No

If **Yes**, Please explain _____

7. Have you ever been treated for cancer? ☐ Yes ☐ No

If **Yes**, Please explain _____

8. Do you have or have you had any of the following diseases or problems? (check all that apply)

Hip / Knee Replacement	☐ Yes ☐ No
Rheumatic Fever or Rheumatic Heart Disease	☐ Yes ☐ No
Heart Trouble, Heart Attack	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Blood Disorders, Anemia	☐ Yes ☐ No
Abnormal Bleeding, Bruises Easily	☐ Yes ☐ No
High or Low Blood Pressure	☐ Yes ☐ No
Hepatitis, Jaundice, Liver Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Women: Are You Pregnant?	☐ Yes ☐ No

SIGNATURE _____ Date _____

Consent For Use And Disclosure

Date:

Charlton Dental Associates

Dennis J. Charlton, DMD - Thomas J. Kosick, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name _____

Address _____

Telephone _____ Social Security Number _____

Section B: To The Patient - Please Read The Following Statements Carefully

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 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 that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 reat you or to continue treating you if you revoke this Consent.

Signature _____ Date _____

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

Personal Representative's Name _____

Releationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the Patient's chart.

Revocation of 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 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.

Signature _____ Date _____

Notice Of Privacy Practices

Date:

Charlton Dental Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Printed Name _____

Signature _____

Date _____

For Office Use Only

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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