



PATIENT INFORMATION

Name _____ Date _____
 Nickname _____ M F
 Address _____
 City _____ State _____ Zip _____
 Birth date _____ Age _____
 Home phone _____ Cell _____
 Work phone _____ Ext _____
 Social Security Number _____ Marital Status S M D
 Email _____
 Employer _____
 General Dentist _____
 In case of an Emergency Contact _____
 Phone _____ Relation _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____
 Insured Name _____
 Social Security # _____ Employer _____
 Relationship to patient _____
 Secondary Insurance Company _____
 Insured Name _____
 Social Security # _____ Employer _____
 Relationship to patient _____

DO YOU HAVE A FLEX PLAN THROUGH WORK Yes No

SPOUSE'S INFORMATION

Name _____ DOB _____
 Work Number _____ cell _____
 Employer _____
 Social Security Number _____

WHO MAY WE THANK FOR REFERRING YOU?

Dentist _____
 Friend _____
 Other _____

MEDICAL HISTORY

Please circle yes or no

Yes No Heart Murmur
 Yes No Asthma
 Yes No Rheumatic Fever
 Yes No Tuberculosis
 Yes No Prolonged Bleeding
 Yes No Cancer
 Yes No Anemia
 Yes No Growth Disorders
 Yes No Kidney Disease
 Yes No Disabilities
 Yes No Liver Disease
 Yes No Emotional Problems
 Yes No Diabetes
 Yes No Fever Blisters
 Yes No Hepatitis
 Yes No Allergies to Latex/Metal
 Yes No Epilepsy
 Yes No Allergies to Medication
 Yes No Fainting
 Have you experienced any health problems? Yes No
 Any major changes in your health recently? Yes No
 Are you currently under physician care? Yes No
 Are you currently taking any medications? Yes No
 Have you been in a risk group for AIDS? Yes No
 Any conditions that you feel we should know about?

What concerns has your dentist expressed about your bite?

Yes No Wear or fracture of teeth
 Yes No Bone/Gum loss
 Yes No Difficulty with cleaning as a result of crowding
 Yes No Other _____

Please indicate history of:

Yes No Clenching Teeth
 Yes No Sleep Apnea
 Yes No Grinding Teeth
 Yes No Frequent Headaches
 Yes No Jaw Joint Problems
 Yes No Speech Problems

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that the information that I have given today is complete and accurate. I understand that it is my responsibility to inform the office of any changes.

Signature _____ Date _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

Please circle the following:

Yes No **I consent to the taking of photographs, x-rays, and models before, during and after treatment. Dr. Kofford may share the same with other dentists in regard to my treatment.**

Yes No **I consent to my picture being placed on the *in-office* bulletin board when appliances are removed.**

Yes No **If you were referred by your doctor or a friend may we thank them?**

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient name: _____ Date: _____

Signature: _____ Date: _____
(parent or guardian if patient is under the age of 18)

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, manager and doctor continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization or retaliation if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problem so that we may remedy the situation promptly.

THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS.