WELCOME TO OUR PRACTICE!

Patient's Name_____ Birthdate_____

Home Address_____ Home Phone_____

City_____ Zip_____ Social Security #_____

Cellular_____ Pager_____ E-Mail_____

Single_____ Married_____ Divorced_____ Separated_____ Widowed_____ Minor_____

Employed By _____ Occupation_____

Business Address_____ Work Phone_____

Name of Parents/Guardian (if minor)_____ Phone_____

Name of Spouse_____ Closest Relative_____ Phone_____

Spouse or Parent/Guardian Employed By_____ Occupation_____

Dental Insurance Company_____ Subscriber's Name_____

Subscriber's Social Security #_____ Subscriber's Birthdate_____

Person Responsible for This Account & Relationship to Patient_____

How Did You Hear of This Office?_____

Physician's Name_____ Phone_____

Date of Last Physical Examination_____ Reason_____

Date of Last Dental Visit_____ Reason_____

Reason for This Visit_____ Former Dentist_____

Person to Contact in Case of Emergency_____ Phone_____

Have you ever had or been treated for any of the following conditions or diseases? Your answers are for our records only and will be considered confidential. There may be additional questions concerning your health.

( ) Recent Illness
( ) AIDS or HIV Infection
( ) Anemia
( ) Arthritis or Painful Swollen Joints
( ) Asthma
( ) Bleeding Tendency
( ) Cancer
( ) Diabetes
( ) Epilepsy
( ) Fainting Spells or Seizures
( ) Heart or Chest Pains
( ) Heart Disease
( ) Heart Murmur
( ) Hepatitis, Jaundice or Liver Disease
( ) High Blood Pressure
( ) Kidney Trouble
( ) Low Blood Pressure
( ) Lung Disease
( ) Problems with the Immune System
( ) Problems with Mental Health
( ) Respiratory Problems, Bronchitis, Emphysema, Etc.
( ) Rheumatic Fever
( ) Sexually Transmitted Disease
( ) Sinus Trouble
( ) Stroke
( ) Thyroid Problems
( ) Tuberculosis
( ) Tumor or Growths
( ) Ulcer
( ) Other_____

Are you allergic or have you had a reaction to:

( ) Aspirin
( ) Barbiturates or Sleeping Pills
( ) Codeine or Other Narcotics
( ) Local Anesthetic
( ) Penicillin or Other Antibiotics
( ) Sulfa Drugs
( ) Other_____

Are you in good health? ..... Yes No
Has there been any change in your general health within the past year? ..... Yes No
Have you ever required a blood transfusion? ..... Yes No
Have you ever been put to sleep for an operation? ..... Yes No
If so, please explain _____
Have you been hospitalized within the last 5 years? ..... Yes No
If so, please explain _____
Are you a smoker? ..... Yes No
Do you regularly consume alcohol? ..... Yes No
(Women) Are you pregnant or nursing? ..... Yes No
(Women) Are you now taking birth control pills? ..... Yes No
Are you presently under the care of a physician? ..... Yes No
If so, please explain _____
Have you ever responded unfavorably to medical or dental care? ..... Yes No
If so, please explain _____
Are you now taking any medicine(s) including non-prescription medicine? ..... Yes No
If so, what are you taking? _____
Do you have any disease, condition, or problem not listed above that I should be aware of? ..... Yes No
If so, please explain _____

I certify that the information on these two pages is true and correct. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of these forms. Furthermore, I will update this information in a timely manner should any changes occur.

It is our office policy for patients to pay for their dental care at the time their services are rendered, unless prior financial arrangements have been made. If you have dental insurance, our office will gladly process your claim forms. Your estimated balance will be collected for the care provided each day and a statement may be sent for any balance due after we have received payment from your insurance company.

Your dental health is important to us and as such, any future appointments that you schedule with our office will be reserved especially for you. Should an emergency occur which prevents you from keeping your appointment, kindly notify our office at least 24 hours prior so that we may allow another patient to take your place.

I hereby authorize the office of Melvin T. Yamada, D.D.S. to provide any insurance company(s), claim administrator(s), and consulting health care professionals with information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

I further authorize payment of any dental benefits otherwise payable to me directly to Melvin T. Yamada, D.D.S.

I also authorize the office of Melvin T. Yamada, D.D.S. to provide dental treatment, as they deem necessary.

_____ _____

Patient or Authorized Guardian's Signature Date

CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, Dr. Yamada. is required under federal law to obtain your consent. Please review this consent. If you agree with its terms, please sign and date this consent below.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or health care operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I, _____ (name of patient), hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between me and Dr. Yamada No other individuals/organizations have permission to obtain my confidential information under this consent.

This consent form will be kept in your patient file for a period of six (6) years.

_____

Authorized Signature (Adult Patient, Parent, Legal Guardian)

_____

Print Name

_____

Date

For dentist use only:

Date Received: _____

Signature of Recipient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this dental
(name of patient)
office's Notice of Privacy Practices.

_____

Authorized Signature (Adult Patient, Parent, Legal Guardian)

_____

Print Name

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barrier prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (please specify):

_____

_____

_____

_____

_____

Dental Office Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and Dr.'s certifications.

I acknowledge that upon request I may receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office may change the Notice of Privacy Practices and that I may contact the office to obtain a current copy.

I understand that I may request that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Signature: _____

Guardian Name (if patient is a minor): _____

Guardian Signature: _____

Date: _____