LOYALSOCK
DENTAL ASSOCIATES

PATIENT INFORMATION

TODAY'S DATE _____

PATIENT NAME

FIRST MIDDLE LAST HOW YOU WOULD LIKE TO BE ADDRESSED?

HOME ADDRESS

_____

_____

PHONE HOME _____

BUSINESS _____

MOBILE _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMPLOYER/OCCUPATION _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

GENDER ☐ MALE ☐ FEMALE

TEXT REMINDERS ☐ YES ☐ NO

EMERGENCY CONTACT

FIRST LAST PHONE RELATION TO PATIENT

ARE ANY FAMILY MEMBERS PATIENTS WITH US? WHO?

_____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

INSURANCE AND BILLING INFORMATION

RESPONSIBLE PERSON FOR ACCOUNT

FIRST LAST

RELATION TO PATIENT

DATE OF BIRTH SOCIAL SECURITY #

EMPLOYER NAME

DENTAL INSURANCE COMPANY

GROUP ID INSURANCE ID NUMBER

DENTAL HISTORY

REASON FOR TODAY'S VISIT

_____

_____

FORMER DENTIST

_____

DATE OF LAST DENTAL CARE

_____

AUTHORIZATION

☐ **I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care.**
☐ **I understand that a fee may be charged for broken appointments as well as appointments canceled with less than 24 hour notice.**
☐ **I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits.**
☐ **I understand that all professional services are charged directly to the patient and that I am responsible for payment of feed including all collection/attorney fees.**

RESPONSIBLE PARTY NAME SIGNATURE DATE

_____ _____ _____

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MEDICAL HISTORY

TODAY'S DATE _____

MEDICAL DOCTOR'S NAME _____

DATE OF LAST VISIT WITH DOCTOR _____

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATIONS WITHIN 5 YEARS? IF YES, PLEASE DESCRIBE

_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? WHEN?

_____

FOR WOMEN

ARE YOU PREGNANT? ☐ YES ☐ NO
ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO
ARE YOU NURSING? ☐ YES. ☐ NO

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS/HIV POSITIVE
☐ ANEMIA
☐ ARTHRITIS, RHEUMATISM
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ASTHMA
☐ AUTOIMMUNE DISEASE
☐ BACK PROBLEMS
☐ BISPHOSPHONATE
☐ BLOOD DISEASE
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CHEMO/RADIATION THERAPY
☐ CIRCULATORY PROBLEMS
☐ CORTISONE TREATMENTS
☐ COUGH, PERSISTENT
☐ COUGH UP BLOOD
☐ DIABETES
☐ EPILEPSY
☐ FAINTING
☐ GASTROINTESTINAL
☐ DISORDER GLAUCOMA
☐ HEADACHES
☐ HEART MURMUR
☐ HEART PROBLEMS, DESCRIBE
_____
☐ HEMOPHILIA
☐ HEPATITIS A/ B /OTHER
☐ HIGH BLOOD PRESSURE
☐ JAW PAIN
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MITRAL VALVE
☐ PROLAPSE NERVOUS
☐ PROBLEMS
☐ PACEMAKER
☐ PSYCHIATRIC CARE
☐ RADIATION TREATMENT
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ SHORTNESS OF BREATH
☐ SKIN RASH
☐ SLEEP APNEA
☐ STROKE
☐ SWELLING OF FEET/ANKLES
☐ THYROID PROBLEMS
☐ TOBACCO HABIT
☐ TUBERCULOSIS
☐ ULCER
☐ VENEREAL DISEASE

INDICATE ANY ALLERGIES TO THE FOLLOWING:

☐ ASPIRIN ☐ PENICILLIN ☐ LATEX ☐ IODINE DYE ☐ CODEINE ☐ SULFA ☐ DENTAL RESTORATIVE MATERIALS

PLEASE LIST ANY OTHER ALLERGIES _

_____

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING:

_____

DESCRIBE ANY OTHER MEDICAL CONDITIONS WE SHOULD BE AWARE OF:

_____

PRINT NAME _____

PATIENT SIGNATURE _____ **DATE** _____

DOCTOR SIGNATURE _____ **DATE** _____

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CONSENT FOR SERVICES

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. *Initial:*___

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. *Initial:*___

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication. *Initial:*___

4. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. *Initial:*___

5. I hereby give the doctor the absolute right and permission to use my photograph/slides for education or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides. *Initial:*___

6. I acknowledge that I reviewed Loyalsock Dental Associates HIPAA and Notice of Privacy Practices. A copy is available upon request. *Initial:*___

_____

Signature of Patient, Parent, or Guardian Date Relationship to Patient

LOYALSOCK
DENTAL ASSOCIATES

PATIENT PRIVACY RELEASE FORM

I consent to disclosure of the following protected health information about me to the following family members, medical or dental providers (involved in my dental care such as referring doctors), or persons (insurance companies) involved in my care or payment of my care for the following that may apply:

- All dental/medical information
- Information necessary to schedule appointments for me
- Lab results/radiographs
- Information necessary to provide for calling in or picking up prescriptions
- Information necessary to my family members, persons, and dental/medical providers
- Information necessary to bill for or submit claims for care provided for me by my dental insurance or FSA accounts

I authorize this Health Provider and/or staff to leave medical or account information pertaining to my care by the following methods and will assume responsibility to notify them wheNever this information changes:

Home/Cell Telephone	____ Yes	_____ No
Work Telephone	____ Yes	_____ No

Please list names of authorized persons:

_____ _____

_____ _____

Rights of the patient

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclose in this document by sending written authorization to Joyce Kim, DDS.

I understand that I have the right to refuse to sign this authorization and that any treatment will not be conditioned on signing this authorization.

This authorization shall be effective until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Patient/Parent/Guardian Date

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RECORDS RELEASE FORM

I,_____, authorize Loyalsock Dental Associates to request the following records from my previous dentist.

Previous Dentist: Name: _____

Address:_____

City:_____

Phone:_____

Fax: _____

Please note that Loyalsock Dental Associates is requesting the following records:

1. All x-rays from the last five years
2. All perio readings
3. Recommended treatment and treatment plans

_____ _____

Signature Date

Note to patients: Please send this form back either by fax to: 570-323-5850 or scan and email to loyalsockdental@gmail.com before your appointment.

Note to doctor: Loyalsock Dental Associates is a chartless office and would prefer that the above records be sent via email to the loyalsockdental@gmail.com. Records may also be sent to:

Loyalsock Dental Associates
1501 Washington Blvd.
Williamsport, PA 17701