

Patient Information Please fill application out completely on both sides.

Patient Name:	Patient	t Name:					Date:		
Social Security #: Birth Date: /	N	Last	First Married	Single Child	MI O	her Nickn	ame,		
Social Security #: Birth Date: /		remaie	IVIAITIEU	SingleCiniu	0	inei Mickii	or	preferred name	
Cell phone #:	Social	l Security #:		Birth D	ate:	1	1		
Cell phone #:		E-mail:				Home	#:		
Tues Wed Thurs Fri Sat Address: Street	Cell pl	hone #:	• • • • • • • • • • • • • • • • • • • •	Work:		hapid i	Ext.)		
TuesWedThursFriSat	Prefer	rred appt. times:	Morning	Afternoon	Ever	ning(Tue, We	d & Thurs)	Any time	
Street Apartment #	т.,	XX7-J	71	Dai: Can					
City State Zip Code ***We request your e-mail so we can send you e-mail reminders for your appointments so that confirming your appointment will only be a click away! **We request your cell phone number so that we can contact you the day of your appointment should there be and emergency. Heath Information Date of last dental visit: Reason for this visit: Do you or have you had any of the following? Please check only those that apply which may affect dentist very considered in the property of the following? Please check only those that apply which may affect dentist very considered in the property of the following? Please check only those that apply which may affect dentist very considered in the property of the following? Please check only those that apply which may affect dentist very considered in the property of the property of the following? Please check only those that apply which may affect dentist very considered in the property of the property of your appointment should there be and energency. Heath Information Reason for this visit: Peason for this visit: Paccomaker Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Pregnancy: Due date Radiation Treatment Pregnancy: Due date Respiratory Problems Respiratory Problems Respiratory Problems Pharmacy Telephone Pharmacy T	A	ddress:	_						
***We request your e-mail so we can send you e-mail reminders for your appointments so that confirming your appointment will only be a click away! **We request your cell phone number so that we can contact you the day of your appointment should there be and emergency. Halth Information			S	reet		Apar	tment #		
Health Information Reason for this visit:									
Date of last dental visit:				phone number so that we can con	ntact you th	ne day of your appo			
Do you or have you had any of the following? Please check only those that apply which may affect dentist very like the part of the following? Please check only those that apply which may affect dentist very like the past two years? Program Pr									
□ HIV □ Fainting □ Pacemaker □ Allergies □ Glaucoma □ Pregnancy: Due □ Codeine Allergy □ Hay fever □ Radiation Treatment □ Penicillin Allergy □ Head Injuries □ Respiratory Problems □ Anemia □ Heart Disease □ Rheumatic Fever Pharmacy Telephone □ Arthritis □ Heart Murmur □ Rheumatism □ Rheumatism □ Arthritis □ Heart Murmur □ Rheumatism □ Stonus Problems □ Asthma □ High blood pressure □ Stomach Problems □ Blood Disease □ Low Blood Pressure □ Stroke □ Doctor Signature: □ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Epilepsy □ Mental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other • Have you ever had any complications following dental treatment? _YesNo If yes what medication? _YesNo If yes what medication? _YesNo If yes, please explain:: _YesNo <									
Allergies	Do yo	u or have you ha	d any of the	e following? Please ch			apply which	ch may affect <u>dentist vis</u>	
Allergies		HIV		Fainting		Pacemaker			
□ Codeine Allergy □ Hay fever □ Radiation Treatment □ Penicillin Allergy □ Head Injuries □ Respiratory Problems □ Anemia □ Heart Disease □ Rheumatic Fever Pharmacy Telephone □ Arthritis □ Heart Murmur □ Rheumatism □ Rheumatism □ Pharmacy Telephone □ Artificial joints □ Hepatitis □ Sinus Problems □ Stroke □ Doctor Signature: □ Blood Disease □ Low Blood Pressure □ Stroke □ Doctor Signature: □ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Excessive Bleeding □ Nental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other • Have you ever had any complications following dental treatment? YesNo If yes what medication? _ YesNo • Have you been admitted to a hospital or had emergency care during the past two years? _ YesNo If yes, please explain:: _ No • Are you under the care of a physician? _ YesNo		Allergies		Glaucoma		Pregnancy:	Due		
□ Penicillin Allergy □ Head Injuries □ Respiratory Problems □ Anemia □ Heart Disease □ Rheumatic Fever □ Arthritis □ Heart Murmur □ Rheumatism □ Artificial joints □ Hepatitis □ Sinus Problems □ Asthma □ High blood pressure □ Stomach Problems □ Blood Disease □ Low Blood Pressure □ Stroke □ Doctor Signature: □ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Excessive Bleeding □ Nervous Disorders □ Venereal Disease □ Have you ever had any complications following dental treatment? _YesNo If yes what medicated for dental treatment? _YesNo If yes what medication? _YesNo • Have you been admitted to a hospital or had emergency care during the past two years? _YesNo If yes, please explain:: YesNo					-				
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□ Blood Disease □ Low Blood Pressure □ Stroke Doctor Signature: □ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Epilepsy □ Mental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other • Have you ever had any complications following dental treatment? _YesNo Please explain if yes:		Artificial joints		Hepatitis		Sinus Probl	lems		
□ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Epilepsy □ Mental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other		Asthma		High blood pressure		Stomach Pr	oblems		
□ Cancer □ Jaundice □ Tuberculosis □ Diabetes □ Kidney Disease □ Tumors □ Dizziness □ Liver Disease □ Ulcers □ Epilepsy □ Mental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other • Have you ever had any complications following dental treatment? _ YesNo Please explain if yes: _ YesNo. • Are you pre-medicated for dental treatment? _ YesNo. If yes what medication? _ No. • Have you been admitted to a hospital or had emergency care during the past two years? _ YesNo If yes, please explain:: _ No Are you under the care of a physician?YesNo		Blood Disease		Low Blood Pressure		Stroke		Doctor Signature:	
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 □ Epilepsy □ Mental Disorders □ Venereal Disease □ Excessive Bleeding □ Nervous Disorders □ Other □ • Have you ever had any complications following dental treatment?YesNo Please explain if yes:		Diabetes		Kidney Disease		Tumors			
Excessive Bleeding		Dizziness		Liver Disease		Ulcers		(4)	
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Please explain if yes: Are you pre-medicated for dental treatment?YesNo. If yes what medication? Have you been admitted to a hospital or had emergency care during the past two years?YesNo If yes, please explain:: Are you under the care of a physician?YesNo			ing $\square N$	ervous Disorders		Other			
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 Have you been admitted to a hospital or had emergency care during the past two years?YesNo If yes, please explain:: Are you under the care of a physician?YesNo 									
 Are you under the care of a physician?YesNo 	•	Have you been admitted to a hospital or had emergency care during the past two years?YesNo							
If yes, please explain:Phone:Phone:Phone:		Are you under the	care of a ph	vsician? Yes N	lo		•		
 Name of physician: Phone:	=	If yes, ple	ase explain:			- Di			
 Do you have any health problems that need further clarification?YesNo 	•	Name of physicia	n:			Phone:			
	•	Do you have any	health proble	ms that need further clari	itication	1?Yes _	No		

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The following is for Employer Name &			-		ible for paymen		occupation:	
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Name of insured:					Birth Date:	- 1	1	
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Patient's relations								
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Insurance address					1, 44,			
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RELEASE OF INFORMATION

I,	give Dr. Millan of Smile 32 my
I,	owing patients:
To be sent to:	
Patient/ Parent/ Guardian Signature	•
Date	
Relationship to the patient	
relationship to the patient	





Patient Name:	Date:				
Patient Social Security No:	Patient DOB:				
Current Me	ent Medications				
Medication Name	Dosage				
1					
2					
3					
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6					
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8					
9.					
10	,				
11					
12					
Doctor Signature:	Date:				

From the office of:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights-section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Office Staff Signature_

Witnessed Staff Signature____

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check any that you DO NOT want the office to call, we will be using the numbers/emails you have updated, on your

Account information. All information is subject to availability to verify and validate. __Work Cell __Work Phone __Work Email __Work Fax __Mail to Work __Personal Cell __Home Phone __Home Email __Home Fax __Mail to Home __Emerg. Contact __Interpreter Contact ___ Any of the above List names of who can have access to your State what part of your chart: Financial, Treatment, dental/medical chart information: Circle Type. Health history, is allowed to be disclosed or copied Full access / Partial access Full access / Partial access Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports. diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered. Print Patient's Name: _____ Date ____ Print Legal Guardian's Name: ______ Date Signature of Patient or Legal Guardian: Date Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Printed Name_____Date____