To Dr:

Email:

Phone #_____

Records Release Authorization For:

Name:

Address:

Phone #_____

Date of Birth:

Signature:

Please forward copies of any patient records that your office holds and are current for myself and family member if applicable, to:

Andrew J. Smith DMD

2200 Bryant Williams Drive

Klamath Falls, OR 97601

Phone # (541) 884-1331

Email: Klamathfallsdentist@gmail.com

ANDREW J. SMITH, DMD

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY:

NAME:_____ DOB:_____

HOME ADDRESS:_____

BILLING ADDRESS:_____

CELL PHONE:_____ WORK PHONE:_____

AGE:_____ MALE:_____ FEMALE:_____

MARITAL STATUS: MARRIED:_____ SINGLE:_____ DIVORCED:_____ WIDOWED:_____

EMPLOYER:_____

IF COVERED BY ANOTHER PERSON'S INSURANCE, PLEASE PROVIDE:

NAME OF POLICY HOLDER:_____

POLICY HOLDERS DOB: _____ POLICY HOLDER'S EMPLOYER:_____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S INFORMATION:

NAME:_____

HOME ADDRESS:_____

CELL PHONE:_____ WORK PHONE:_____

EMPLOYER:_____

IN CASE OF AN EMERGECY:

RELATIVE TO CONTACT:_____

RELATIONSHIP TO PATIENT:_____ PHONE #:_____

ANOTHER PERSON TO CONTACT, OTHER THAN A RELATIVE:_____

RELATIONSHIP TO PATIENT:_____ PHONE #:_____

WHO REFERRED YOU TO OUR OFFICE?_____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

CONSENT: I AM AWARE THAT MY ACCOUNT WILL INCUR A 1.5% FINANCE CHARGE AFTER 90 DAYS. I UNDERSTAND THAT MY INSURANCE IS BILLED AS A COURTESY, THAT I AM RESPONSIBLE TO KNOW MY INSURANCE BENEFITS AND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT, REGARDLESS OF INSURANCE.

SIGNATURE: _____ DATE: _____

NAME: _____ DOB: _____
LAST FIRST MIDDLE INITIAL

CHANGE OF ADDRESS NO: ____ YES: NEW ADDRESS _____

_____

NEW PHONE NUMBER(S): No: ____ YES: (____) _____

EMAIL ADDRESS: _____

DO YOU HAVE DENTAL INSURANCE? NO: ____ YES: ____ PLEASE GIVE THE FRONT DESK A COPY

NAME OF MEDICAL PHYSICIAN:_____

LIST ALL CURRENT MEDICATIONS: _____

_____

LIST ALL KNOWN ALLERGIES: _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT

ARTIFICIAL JOINT (HIP, KNEE, ETC)	YES	NO	DIABETES	YES	NO
HEART DISEASE/ATTACK	YES	NO	RADIATION/CHEMOTHERAPY	YES	NO
HEART SURGERY	YES	NO	OSTEOPOROSIS/OSTEOPENIA	YES	NO
HIGH BLOOD PRESSURE	YES	NO	PSYCHIATRIC TREATMENT	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	THYROID PROBLEMS	YES	NO
STROKE	YES	NO	ASTHMA/EMPHYSEMA	YES	NO
KIDNEY TROUBLE	YES	NO	SINUS TROUBLE	YES	NO
LIVER DISEASE	YES	NO	TUBERCULOSIS	YES	NO
HEPATITIS: TYPE: A B C	YES	NO	ULCERS	YES	NO
HIV POSITIVE	YES	NO	FAINTING/DIZZY SPELLS	YES	NO
AIDS	YES	NO	COLD SORES/FEVER BLISTERS	YES	NO
HEMOPHILIA	YES	NO	DEVELOPMENTALLY DISABLED	YES	NO
BRUISE EASILY	YES	NO	DRUG ADDICTION	YES	NO
EPILEPSY/SEIZURES	YES	NO	NERVOUSNESS	YES	NO

WOMEN ONLY: ARE YOU PREGNANT? _____ WHAT MONTH? _____ ARE YOU NURSING? _____

ANY OTHER DISEASE, CONDITION OR PROBLEM THAT IS NOT LISTED ABOVE: _____

_____

CONSENT: The undersigned herby authorizes the Doctor to take x-rays, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the Doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate mediation/therapy indicated for such treatment. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent for the Doctor to choose and employ such assistance as deemed fit to provide recommended treatment. I am aware that my account will incur a 1.5% finance charge after 90 days. I understand that my insurance is billed as a courtesy and I am financially responsible for all charges on this account, regardless of insurance.

SIGNATURE: _____ DATE: _____

PLEASE BRING TO OUR ATTENTION ANY INFORMATION THAT IS DIFFERENT FROM YOUR LAST VISIT

Andrew J Smith DMD
Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of

(Please Print Full Name) this office's Notice of Privacy Practices.

_____

(Signature)

_____

(Date)

I also give my consent that this office may disclose to my spouse or person(s) indicated below, any protected health information.

_____

_____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement Other

(Please Specify)

_____