Privacy and Communication Consent

Patient Name: _____ Date of Birth: _____

Initial Below

I _____ Do Agree I _____ Do not Agree

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am aware the message sent my consists of appointment reminders, recall visits, information request, and patient satisfaction or reviews. I further agree that I am responsible for providing the dental practice any updates to my email address and / or mobile phone number. My most preferred method of electronic communication:

Initial Below

_____ Text messaging

_____ Email Address I would like to receive correspondence at:_____

I can withdraw my consent to electronic communication at any time by calling:
admin@hillrise.com Or 575.522.0454. Thank you
Patient Signature: _____**Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.
****You may refuse to sign this acknowledgment****
I _____ have received a copy of this office's Notice of Privacy Practices.
Sign: _____Date: _____
Authorization to Release information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act of people other than yourself.

I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
{Please Print Name and Relationship}

_____
{Please Print Name and Relationship}

_____
{Please Print Name and Relationship}

Office Use: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:1. Individual refused to sign 2. Communication barriers prohibited obtaining information 3. an emergency prevented acknowledgment 4. Other_____

Hillrise Dental

Patient name: _____Preferred name: _____DOB_____
Mailing Address: _____City: _____State: _____ Zip: _____
SSN: _____ Gender: Female Male Marital status: Married Single Domestic Partner Minor child
Cell phone: _____ Home phone: _____Email address: _____
Whom may we thank for referring you to our Practice? _____

Primary Insurance

Primary Insured: _____ DOB: _____ SSN: _____
Address: _____ City: _____State: _____ Zip: _____
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: _____Dental Insurance Company: _____ ID #: _____

Federal Employees

Federal Employee Medical Insurance: BCBS ID: R_____ Basic/PPO GEHA ID: _____

Secondary Insurance

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____State: _____ Zip: _____
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: _____Insurance Company: _____ID #: _____

Responsible Party (This must be filled out please)

Name: _____ Relationship to patient: _____
Address: _____ City: _____State: _____ Zip: _____
DOB: _____ SSN: _____ Daytime Phone: _____
Employer: _____ Work phone: _____

Insurance Policy

Your insurance contract is an agreement between your insurance company and yourself. We are not a party to that contract. Your complete insurance information must be presented at the time services are provided. All insurance co-pays and deductibles must be paid at the time of service. Insurance claims are electronically filled to expedite carrier payments, however, the patient is responsible for any unpaid charges due to exclusions and limitations written in per your plan provisions. I hereby authorize Hillrise Dental to furnish information to my dental carrier concerning my treatment and I hereby assign to the doctors all payments for dental treatment rendered to myself or my dependents.

No-Show/ Late Cancellation/Late Charges

- There is a charge of $25.00 for not showing up for your scheduled appointments. This charge can be waived when you call to reschedule your appointment and notify us of the reason for the no show to the previous appointment. If your account shows repeated missed appointments or cancellations without 48 hours' notice, you may be asked to secure your next appointment with a deposit which will be forfeited if you do not show for the appointment that required a deposit
- I am aware that failure to keep this account current may result in the doctor being unable to provide additional dental services. In the case of default on payment of this account for any reason, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signed: _____ Date: _____

Patient Medical History

Do you have or have you had any of the following? Please circle Y for yes or N for no on all three columns

Y N Heart Disease	**Y N** Heart Murmur/MVP	**Y N** Stroke
Y N Congenital Heart Lesions	**Y N** Rheumatic Fever	**Y N** Pacemaker
Y N Stent	**Y N** High Blood Pressure	**Y N** Anemia
Y N Prolonged Bleeding Disorder	**Y N** Low Blood Pressure	**Y N** Asthma
Y N Hay fever	**Y N** Sinus Trouble	**Y N** Epilepsy/Seizure
Y N Ulcers	**Y N** Liver Disease	**Y N** Jaundice
Y N Hepatitis Type _____	**Y N** Diabetes	**Y N** Arthritis
Y N Kidney Disease	**Y N** Radiation Therapy	**Y N** Tumor/Malignancy
Y N Cancer/Chemotherapy	**Y N** Immune Suppressed Disorder Type: _____	
Y N HIV/AIDS	**Y N** STI/Herpes	**Y N** Hearing loss
Y N Fainting Spells	**Y N** Glaucoma	**Y N** Depression
Y N Pregnant	**Y N** Nursing	**Y N** Taking Birth Control
Y N Artificial Joints: Where_____	_____	**Y N** Implants (cosmetic)(medical) (dental)
Y N Thyroid	**Y N** TB or Lung Disease	**Y N** E-cigarettes/ Vape
Y N Smoke/ chew Tobacco	_____ per day Years:_____	Have you quit? Y N When:_____
Y N Substance Abuse: What_____	_____ How often:_____	Have you quit? Y N When:_____

Y N Do you take Fosamax, Boniva, Actonel, Aredia, Zometa, etc. For Osteoporosis or any other condition?

Y N Had major Surgery? Year: _____ Type:_____ Year:_____ Type:_____

Are You Allergic to any of the following? (Please Circle)

Aspirin Ibuprofen Sulfa Drugs Penicillin Codeine Latex Local Anesthetics

Other allergies to medications: _____

Please List the medications you are currently taking with dosage and for what condition (Including over the counter medication & Aspirin)

RX:_____ Condition_____ How often?_____

RX:_____ Condition_____ How often?_____

RX:_____ Condition_____ How often?_____

RX:_____ Condition_____ How often?_____

Primary Medical Care Doctor: _____ Phone: _____

Patient Dental History

What is the reason for your appointment today? _____

Previous Dentist_____ Last Visit_____ Last Cleaning_____

Are you nervous about seeing the dentist? Y N Please Explain _____

How often do you brush? _____ Floss?_____

(Please Circle)

Y N I clench or grind my teeth during the day or while sleeping	**Y N** My gums feel tender or sore
Y N I My gums Bleed while brushing or flossing	**Y N** I have eating problems
Y N I have had orthodontics	**Y N** I have had gum Surgery
Y N I have had oral surgery	**Y N** I prefer tooth colored fillings

Y N Would you like to change anything about your smile? Explain? _____

What are you dental priorities?_____

Consent

I Understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the Providers at Hillrise Dental to perform any necessary dental services, with my informed consent, that may be needed during diagnosis and treatment.

Signed:_____ Date:_____