SERENITY VALLEY
Family Dentistry

ABOUT YOUR CHILD

Name: _____ □ Female □ Male

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____/_____/_____ Grade: _____ Is this your child's first dental visit? □ Yes □ No

Email Address: _____

How did you hear about our office? _____

EMERGENCY INFORMATION

Emergency contact: _____

Relationship: _____ Phone: _____

I give permission for Serenity Valley Family Dentistry to share my child's medical and account information with:

_____

DENTAL HISTORY

Do you have any concerns with your child's teeth, such as a chipped tooth, decayed tooth, gumboil, etc.?
□ Yes □ No If Yes, please explain: _____

How often does your child brush? _____ How often does your child floss? _____

Has your child required hospitalization or had a serious illness? □ Yes □ No
If yes, please explain: _____

Are your child's immunizations up to date? □ Yes □ No
Is your child sensitive/allergic to anything? □ Yes □ No
If yes, please explain:

_____

Is your child presently taking medications? □ Yes □ No
If yes, please explain: _____

Please check any of the following that apply to your child:

□ Anemia
□ Asthma
□ Attention disorders
□ Breathing disorders
□ Counseling
□ Diabetes
□ Epilepsy
□ Hay fever
□ Hearing impairment
□ Heart murmur
□ Mitral valve prolapse
□ Rheumatic fever
□ Visual impairment
□ Other _____

The information I have given is true and accurate to the best of my knowledge.

Eaglesoft Medical History (UPDATED)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications or supplements?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Radiation/Chemotherapy Treatments	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Bleeding disorder	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No
Anxiety/Depression	◯ Yes ◯ No	Acid relux	◯ Yes ◯ No	Sleep disorder	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments/ Emergency contact

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

SERENITY VALLEY
Family Dentistry

Thank you for choosing Serenity Valley Family Dentistry. We believe that it is our responsibility to use our best professional care, skill, and judgement in helping you achieve your dental health goals.

We reserve your scheduled appointment time just for you. As a courtesy to our team and other patients in the schedule, please arrive on time. Late arrivals will be worked into the schedule if time allows or reappointed to another day.

We will verify your insurance. However, verification of benefits is not a guarantee of payment. You are responsible for all charges not paid by insurance at your scheduled appointment. Any balance after 90 days will be sent to collections.

If you need to reschedule your appointment, we kindly request that you contact us by phone with advanced notice of 2 business days. We understand that situations can arise although, failing your appointment or cancelling multiple times without notice will result in a fee and discontinuation of services at our offices.

Our office will make every effort to confirm your appointment. If it goes unconfirmed 2 business days prior to the appointment, we reserve the right to take you out of the schedule due to no confirmation.

Signature: _____

Date: _____

Parent/Guardian Signature (if patient is under 18 years of age): _____

Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient | Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

Advance Beneficiary of Noncoverage

Commercial insurance

By signing, you are stating:

If my insurance provider does not pay for services completed, I understand that **I will be responsible**. I understand that insurance does do not pay for everything, even care that I need and/or my health care provider recommends.

Please choose one of the following options with a check and initial:

- □ **Option 1**: I understand that insurance may not cover and **WOULD** like to move forward with scheduled care and treatment at Serenity Valley Family Dentistry. _____

- □ **Option 2**: I understand that insurance may not cover and **WOULD NOT** like to move forward with scheduled care and treatment at Serenity Valley Family Dentistry. _____

Here at Serenity Valley Family Dentistry, we value patient health and understand that financial situations may arise. We will always work together to help you receive the care that is necessary, no matter your financial situation. If there is anyway that we can assist you in questions that you may have about payment plans, Care Credit, or service fees, please feel free to ask.

Signature: _____ Date: _____