SOC. SEC. # ______________

DATE ______________

PATIENT INFORMATION

CONFIDENTIAL

NAME ______________ (FIRST / MI / LAST) BIRTH DATE ______________ HOME PHONE ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

E-MAIL ______________ CELL PHONE ______________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER ______________ WORK PHONE ______________

BUSINESS ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

SPOUSE OR PARENT/GUARDIAN'S NAME ______________ EMPLOYER ______________ WORK PHONE ______________

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE ______________ CITY ______________ STATE ______

WHOM MAY WE THANK FOR REFERRING YOU? ______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________ PHONE ______________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________ HOME PHONE ______________

E-MAIL ______________ CELL PHONE ______________

DRIVER'S LICENSE # ______________ BIRTH DATE ______________ FINANCIAL INSTITUTION ______________

EMPLOYER ______________ WORK PHONE ______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______________

BIRTH DATE ______________ SS # / SIN ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________ CITY ______________ STATE ______ ZIP ______

INSURANCE COMPANY ______________ GROUP # ______________ UNION OR LOCAL # ______________

INS. CO. ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______________

BIRTH DATE ______________ SS # / SIN ______________ DATE EMPLOYED

NAME OF EMPLOYER ______________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________ CITY ______________ STATE ______ ZIP ______

INSURANCE COMPANY ______________ GROUP # ______________ UNION OR LOCAL # ______________

INS. CO. ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

SIGNATURE

X ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

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PATIENT NAME____________________ **Date of Birth**__________ **Today's Date**__________

PATIENT MEDICAL HISTORY

PHYSICIAN ____________________ OFFICE PHONE ____________ DATE OF LAST EXAM __________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking?____________		
3. Have you ever taken bisphosphonates (Medications for osteoporosis)?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you have a history of alcohol or drug abuse?	☐	☐

6. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	☐	☐	Tylenol	☐	☐
			Ibuprofen	☐	☐
Penicillin	☐	☐	Latex	☐	☐
Clindamycin	☐	☐	Vicodin	☐	☐
Other antibiotics	☐	☐	Other________	☐	☐

	YES	NO
7. Do you have a joint replacement? If yes, when was it done?__________	☐	☐
8. WOMEN ONLY:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐
Heart Disease	☐	☐	Heart Murmur	☐	☐
Diabetes	☐	☐	Angina	☐	☐
Cancer	☐	☐	Anemia	☐	☐
Hepatitis	☐	☐	Emphysema	☐	☐
Heart Attack	☐	☐	Arthritis	☐	☐
Fainting / Seizures	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐
Epilepsy / Convulsions	☐	☐	Radiation Therapy	☐	☐
Kidney Disease	☐	☐	Liver Disease	☐	☐
AIDS or HIV Infection	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Respiratory Problems	☐	☐
Acid Reflux	☐	☐	Heart Valve Replacement	☐	☐

10. Do you have any other medical conditions that could affect your dental treatment?

____

COMMENTS

____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

PATIENT DENTAL HISTORY

I Certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____________________

Signature of patient (or parent/guardian if minor)

Doctor's Comments____________________

____

____________ Doctor's Signature ____________ Date__________

STEELE PRINTING 120725

SCOTT M. JANZEN, DDS, INC.

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you and your family with treatment. HIPAA provides certain rights and protections to your as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.

4. The patient understands and agrees to inspections of the office and review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.

7. The practice agrees to provide the patient with access to their records in accordance with the state law.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I, ________________________, do hereby agree to the terms set forth above and any subsequent
PATIENT/GUARDIAN
changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

DATED: ____________________

____
PATIENT/GUARDIAN SIGNATURE