

PATIENT / ACCOUNT INFORMATION

Cosmetic, Family and Sports Dentistry, LLP
Drs. Belvedere, Lambert, Houck D.D.S.
585 Southdale Medical Center, Edina, MN 55435

I. PATIENT INFORMATION

Name:
How do you wish to be addressed?:
Address:
City: St: Zip:
Home Ph: Work Ph:
Cell Phone:
E-mail Address:
Date of Birth: Sex: Male Female
Soc Sec #:
Is the patient responsible for the account: Yes No
If Yes, please go to Section III "Primary Dental Insurance Coverage"
If No, please complete Section II.
Whom can we thank for this referral?:

II. PERSON RESPONSIBLE FOR ACCOUNT

Is patient a college/post secondary student: Yes No
If Yes, please indicate the current enrollment status:
Full Time Part Time School attending:
Name:
Address:
City: St: Zip:
Home Ph: Work Ph:
Cell Phone:
E-mail Address:
Date of Birth: Sex: Male Female
Soc Sec #:
Relationship to Patient:
Other family members in this practice:

III. PRIMARY DENTAL INSURANCE COVERAGE

Is Patient covered/eligible under an employer dental insurance plan? Yes No
Employer:
Employee Name:
Insurance Plan:
Group Insurance information:
Name: AND/OR Number
Is Employee Name different from Person Responsible for Account? Yes No
Address:
City: St: Zip:
Home Ph: Work Ph:
Cell Phone:
E-mail Address:
Date of Birth: Sex: Male Female
Soc Sec #:

IV. SECONDARY DENTAL INSURANCE COVERAGE

Is Patient covered eligible under another employer dental insurance plan? Yes No
Employer:
Employee Name:
Insurance Plan:
Group Insurance information:
Name: AND/OR Number
Is Employee Name different from Person Responsible for Account? Yes No
Address:
City: St: Zip:
Home Ph: Work Ph:
Cell Phone:
E-mail Address:
Date of Birth: Sex: Male Female
Soc Sec #:

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, and further authorize and consent that Doctor to choose and employ such assistance that he deems fit. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or for my dependents is mine, due and payable at the time that services are rendered unless financial arrangements have been made. I further understand that a 1 .5% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise, to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature - Patient (If 18 years old) Date: Staff:
Parent or Responsible Person: Relationship to Patient:

MEDICAL INFORMATION

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If you answer Yes to any of the following questions or if you are unsure, please explain in the space on the back.

<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
<input type="checkbox"/> <input type="checkbox"/> 1. Has there been any change in your general health within the past year? 2. Your last physical examination was on: _____ 3. Name, address, phone no. of physician: _____ _____ <input type="checkbox"/> <input type="checkbox"/> 4. Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> 5. Currently taking any medication(s)? _____ <input type="checkbox"/> <input type="checkbox"/> 6. Have you been hospitalized for any surgical operation or serious illness? If Yes, please describe: _____ _____ 7. Do you have or have you had any of the following Cardiovascular conditions? <input type="checkbox"/> <input type="checkbox"/> a. Rheumatic fever, Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> b. Heart murmur <input type="checkbox"/> <input type="checkbox"/> c. Congenital heart defect <input type="checkbox"/> <input type="checkbox"/> d. Vascular disease <input type="checkbox"/> <input type="checkbox"/> e. Heart surgery / Angioplasty <input type="checkbox"/> <input type="checkbox"/> f. Vascular surgery <input type="checkbox"/> <input type="checkbox"/> g. Infective endocarditis <input type="checkbox"/> <input type="checkbox"/> h. Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> i. Pacemaker <input type="checkbox"/> <input type="checkbox"/> j. Prosthetic heart valve <input type="checkbox"/> <input type="checkbox"/> k. High blood pressure <input type="checkbox"/> <input type="checkbox"/> l. Low blood pressure <input type="checkbox"/> <input type="checkbox"/> m. Stroke <input type="checkbox"/> <input type="checkbox"/> n. Heart attack (Heart trouble) <input type="checkbox"/> <input type="checkbox"/> o. Angina <input type="checkbox"/> <input type="checkbox"/> p. Heart transplant <input type="checkbox"/> <input type="checkbox"/> q. Other cardiovascular problems: Describe: _____ Other conditions? <input type="checkbox"/> <input type="checkbox"/> r. Liver disease, jaundice <input type="checkbox"/> <input type="checkbox"/> s. Hepatitis A, B, or C <input type="checkbox"/> <input type="checkbox"/> t. Liver transplant <input type="checkbox"/> <input type="checkbox"/> u. Diabetes melitus	Other conditions - cont. <input type="checkbox"/> <input type="checkbox"/> v. Kidney trouble, dialysis, transplant <input type="checkbox"/> <input type="checkbox"/> w. Thyroid problems <input type="checkbox"/> <input type="checkbox"/> x. Allergies <input type="checkbox"/> <input type="checkbox"/> y. Asthma <input type="checkbox"/> <input type="checkbox"/> z. Hay fever <input type="checkbox"/> <input type="checkbox"/> aa. Hives or skin rash <input type="checkbox"/> <input type="checkbox"/> bb. Arthritis, Rheumatism <input type="checkbox"/> <input type="checkbox"/> cc. Orthopedic pins, rods, screws <input type="checkbox"/> <input type="checkbox"/> dd. Joint replacement <input type="checkbox"/> <input type="checkbox"/> ee. Prosthetic devices or implants type: _____ <input type="checkbox"/> <input type="checkbox"/> ff. Anemia <input type="checkbox"/> <input type="checkbox"/> gg. Leukemia <input type="checkbox"/> <input type="checkbox"/> hh. Hemophilia, other bleeding disorders <input type="checkbox"/> <input type="checkbox"/> ii. Tuberculosis <input type="checkbox"/> <input type="checkbox"/> jj. HIV-Infection <input type="checkbox"/> <input type="checkbox"/> kk. AIDS <input type="checkbox"/> <input type="checkbox"/> ll. Venereal disease / STD's <input type="checkbox"/> <input type="checkbox"/> mm. Stomach ulcers <input type="checkbox"/> <input type="checkbox"/> nn. Glaucoma <input type="checkbox"/> <input type="checkbox"/> oo. Chemical dependency - drugs or alcohol 8. Do you have or have you had: <input type="checkbox"/> <input type="checkbox"/> a. Chest pain upon exertion? <input type="checkbox"/> <input type="checkbox"/> b. Shortness of breath after exercise? <input type="checkbox"/> <input type="checkbox"/> c. Ankle swelling? <input type="checkbox"/> <input type="checkbox"/> d. Fainting spells or seizures? <input type="checkbox"/> <input type="checkbox"/> e. Shortness of breath when lying down? <input type="checkbox"/> <input type="checkbox"/> f. Require extra pillows when you sleep? <input type="checkbox"/> <input type="checkbox"/> g. Pallor (white look)? <input type="checkbox"/> <input type="checkbox"/> h. Urinate more than 6 times a day? <input type="checkbox"/> <input type="checkbox"/> i. Thirsty much of the time? <input type="checkbox"/> <input type="checkbox"/> j. Dry mouth much of the time? <input type="checkbox"/> <input type="checkbox"/> k. Sores in the mouth? <input type="checkbox"/> <input type="checkbox"/> l. White lesions in the mouth? <input type="checkbox"/> <input type="checkbox"/> m. Lumps or tumors in the mouth or neck? <input type="checkbox"/> <input type="checkbox"/> n. Unusual weight loss? <input type="checkbox"/> <input type="checkbox"/> o. Night sweats? <input type="checkbox"/> <input type="checkbox"/> p. Diarrhea, nausea, vomiting? <input type="checkbox"/> <input type="checkbox"/> q. Persistent cough, cough up blood? <input type="checkbox"/> <input type="checkbox"/> r. Do you use tobacco? What kind: _____ How much: _____ For how long: _____	9. Have you had any of the following: <input type="checkbox"/> <input type="checkbox"/> a. Abnormal bleeding (after tooth extraction, surgery, etc.)? <input type="checkbox"/> <input type="checkbox"/> b. Bruise easily? <input type="checkbox"/> <input type="checkbox"/> c. Radiation or Chemotherapy? <input type="checkbox"/> <input type="checkbox"/> d. Blood transfusion (Yr _____?) 10. Are you allergic to, or have you had any reactions to: <input type="checkbox"/> <input type="checkbox"/> a. Local anesthetics (novacaine)? <input type="checkbox"/> <input type="checkbox"/> b. Penicillin, other antibiotics? <input type="checkbox"/> <input type="checkbox"/> c. Sulfa drugs? <input type="checkbox"/> <input type="checkbox"/> d. Barbiturates? <input type="checkbox"/> <input type="checkbox"/> e. Sedatives, or sleeping pills? <input type="checkbox"/> <input type="checkbox"/> f. Aspirin or other pain medications? <input type="checkbox"/> <input type="checkbox"/> g. Iodine? <input type="checkbox"/> <input type="checkbox"/> h. Any metals (e.g. nickel, mercury etc.)? <input type="checkbox"/> <input type="checkbox"/> i. Latex, balloons, gloves? <input type="checkbox"/> <input type="checkbox"/> j. Other: _____ 11. Women Only: <input type="checkbox"/> <input type="checkbox"/> a. Are you pregnant or think you may be pregnant? <input type="checkbox"/> <input type="checkbox"/> b. Are you nursing? <input type="checkbox"/> <input type="checkbox"/> c. Are you taking oral contraceptives? 12. Are you taking, or have you taken any of the following: <input type="checkbox"/> <input type="checkbox"/> a. Antibiotics, sulfa drugs? <input type="checkbox"/> <input type="checkbox"/> b. Antihistamines? <input type="checkbox"/> <input type="checkbox"/> c. Aspirin or other pain medication? <input type="checkbox"/> <input type="checkbox"/> d. Codeine? <input type="checkbox"/> <input type="checkbox"/> e. Corticosteroids? <input type="checkbox"/> <input type="checkbox"/> f. Dilantin? <input type="checkbox"/> <input type="checkbox"/> g. Insulin, tolbutamide (orinase) to control blood sugar? <input type="checkbox"/> <input type="checkbox"/> h. Other medication to control blood sugar: _____ <input type="checkbox"/> <input type="checkbox"/> j. Anticoagulants, (blood thinners)? <input type="checkbox"/> <input type="checkbox"/> k. Anti-hypertensives (blood pressure medication)? <input type="checkbox"/> <input type="checkbox"/> l. Digitalis or drugs for heart condition? <input type="checkbox"/> <input type="checkbox"/> m. Nitroglycerine? <input type="checkbox"/> <input type="checkbox"/> n. Tranquilizers?

DENTAL INFORMATION

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Yes No

- 1. Does food tend to become caught between your teeth?
- 2. Do your gums often bleed while brushing?
- 3. Have you noticed any loosening of teeth?
- 4. Have you had an injury to you head, neck or jaw?
- 5. Habits - Do you:
 - a. Clench your teeth while awake or asleep?
 - b. Bite your lips or cheek frequently?
- 6. Do you like your smile?
- 7. Problems of the jaw - Have you noticed:
 - a. Clicking of the jaw?
 - b. Pain (joint, ear, side of face)?
 - c. Difficulty in opening or closing?
 - d. Difficulty in chewing?

Yes No

- 8. Have you had:
 - a. Orthodontic treatment (braces)?
 - b. Oral surgery?
 - c. Gum treatment?
 - d. Your bite adjusted?
 - e. Worn a bite plane or other appliance?
- 9. Are you having dental pain at this time?
- 10. Has anyone in your family had gum treatment?
- 11. Do you supplement your diet with fluoride?
- 12. Date of last dental treatment

13. Date of last teeth cleaning

If you answered Yes to any of the Medical or Dental questions, or if you are unsure, please explain in the space below.

To the best of my knowledge, the above information is complete and correct.

Signature - Patient (or parent/guardian if patient is under age 18)

Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION 8: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Douglas Lambert

Telephone: 952-922-9119

Fax 952-922-2628

Address, 6545 S France Ave Ste 585 Edina MN 55435

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to Continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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