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 patent 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 Patent covered/eligible under an employer dental insurance plan? ☐ Yes ☐ No If Yes, please complete this section:

Employer: ______________________

Employee Name: ______________________

Insurance Plan: ______________________

Group Insurance information:

Name: __________ AND/OR Number __________

Is **Employee Name** different from **Person Responsible for Account?** ☐ Yes ☐ No If Yes, please complete the following:

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 Patent covered eligible under another employer dental insurance plan? ☐ Yes ☐ No If Yes, please complete this section:

Employer: ______________________

Employee Name: ______________________

Insurance Plan: ______________________

Group Insurance information:

Name: __________ AND/OR Number: __________

Is Employee Name different from **Person Responsible for Account?** ☐ Yes ☐ No If Yes, please complete the following:

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.

______________________ Date: __________ Staff: __________
Signature - Patient (If 18 years old)

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.

Yes No

☐ ☐ 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:
____
____
____

☐ ☐ 4. Are you now under the care of a physician?

☐ ☐ 5. Currently taking any medication(s)?
____

☐ ☐ 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'?

- ☐ ☐ a. Rheumatic fever, Rheumatic heart disease
- ☐ ☐ b. Heart murmur
- ☐ ☐ c. Congenital heart defect
- ☐ ☐ d. Vascular disease
- ☐ ☐ e. Heart surgery / Angioplasty
- ☐ ☐ f. Vascular surgery
- ☐ ☐ g. Infective endocarditis
- ☐ ☐ h. Mitral valve prolapse
- ☐ ☐ i. Pacemaker
- ☐ ☐ I. Prosthetic heart valve
- ☐ ☐ k. High blood pressure
- ☐ ☐ 1. Low blood pressure
- ☐ ☐ m. Stroke
- ☐ ☐ n. Heart attack (Heart trouble)
- ☐ ☐ o. Angina
- ☐ ☐ p. Heart transplant
- ☐ ☐ q. Other cardiovascular problems:
  Describe: ____________

Other conditions?

- ☐ ☐ r. Liver disease, jaundice
- ☐ ☐ s. Hepatitis A, B, or C
- ☐ ☐ t. Liver transplant
- ☐ ☐ u. Diabetes melitus

Yes No

Other conditions - cont.

- ☐ ☐ v. Kidney trouble, dialysis, transplant
- ☐ ☐ w. Thyroid problems
- ☐ ☐ x. Allergies
- ☐ ☐ y. Asthma
- ☐ ☐ z. Hay fever
- ☐ ☐ aa. Hives or skin rash
- ☐ ☐ bb. Arthritis, Rheumatism
- ☐ ☐ cc. Orthopedic pins, rods, screws
- ☐ ☐ dd. Joint replacement
- ☐ ☐ ee. Prosthetic devices or implants type: ____________
- ☐ ☐ ff. Anemia
- ☐ ☐ gg. Leukemia
- ☐ ☐ hh. Hemophilia, other bleeding disorders
- ☐ ☐ ii. Tuberculosis
- ☐ ☐ jj. HIV-Infection
- ☐ ☐ kk. AIDS
- ☐ ☐ ll. Venereal disease / STD's
- ☐ ☐ mm. Stomach ulcers
- ☐ ☐ nn. Glaucoma
- ☐ ☐ oo. Chemical dependency - drugs or alcohol

8. Do you have or have you had:

- ☐ ☐ a. Chest pain upon exertion?
- ☐ ☐ b. Shortness of breath after exercise?
- ☐ ☐ c. Ankle swelling?
- ☐ ☐ d. Fainting spells or seizures?
- ☐ ☐ e. Shortness of breath when lying down?
- ☐ ☐ f. Require extra pillows when you sleep?
- ☐ ☐ 9. Pallor (white look)?
- ☐ ☐ h. Urinate more than 6 times a day?
- ☐ ☐ i. Thirsty much of the time?
- ☐ ☐ J. Dry mouth much of the time?
- ☐ ☐ k. Sores in the mouth?
- ☐ ☐ I. White lesions in the mouth?
- ☐ ☐ m. Lumps or tumors in the mouth or neck?
- ☐ ☐ n. Unusual weight loss?
- ☐ ☐ o. Night sweats?
- ☐ ☐ p. Diarrhea, nausea, vomiting?
- ☐ ☐ q. Persistent cough, cough up blood?
- ☐ ☐ r. Do you use tobacco?
  What kind: ____________
  How much: ____________
  For how long: ____________

Yes No

9. Have you had any of the following:

- ☐ ☐ a. Abnormal bleeding (after tooth extraction, surgery, etc.)?
- ☐ ☐ b. Bruise easily?
- ☐ ☐ c. Radiation or Chemotherapy?
- ☐ ☐ d. Blood transfusion (Yr ______?)

10. Are you allergic to, or have you had any reactions to:

- ☐ ☐ a. Local anesthetics (novacaine)?
- ☐ ☐ b. Penicillin, other antibiotics?
- ☐ ☐ c. Sulfa drugs?
- ☐ ☐ d. Barbiturates?
- ☐ ☐ e. Sedatives, or sleeping pills?
- ☐ ☐ f. Aspirin or other pain medications?
- ☐ ☐ 9. Iodine?
- ☐ ☐ h. Any metals (e.g. nickel, mercury etc.)?
- ☐ ☐ 1. Latex, balloons, gloves?
- ☐ ☐ J. Other: ____________

11. Women Only:

- ☐ ☐ a. Are you pregnant or think you may be pregnant?
- ☐ ☐ b. Are you nursing?
- ☐ ☐ c. Are you taking oral contraceptives?

12. Are you taking, or have you taken any of the following:

- ☐ ☐ a. Antibiotics, sulfa drugs?
- ☐ ☐ b. Antihistamines?
- ☐ ☐ c. Aspirin or other pain medication?
- ☐ ☐ d. Codeine?
- ☐ ☐ e. Coritcosteroids?
- ☐ ☐ f. Dilantin?
- ☐ ☐ 9. Insulin, tolbutamide (orinase) to control blood sugar?
- ☐ ☐ h. Other medication to control blood sugar: ____________
- ☐ ☐ J. Anticoagulants, (blood thinners)?
- ☐ ☐ k. Anti-hypertensives (blood pressure medication)?
- ☐ ☐ I. Digitalis or drugs for heart condition?
- ☐ ☐ m. Nitroglycerine?
- ☐ ☐ 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 babe 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 heath 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.

REVOCATION 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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