HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ______________________________
(PRINT NAME PLEASE)

Signature: ____________________________________ Date: ____________

Witness: ____________________________________ Date: ____________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

For office use only:

Patient refused to sign. The following circumstances prohibited the patient from signing the acknowledgment:

____

__________________ __________________

Office Personnel (signature) **Office Personnel (print)**

Date: ____________

PATIENT INFORMATION

Patient ______________________________

Address ______________________________

City State Zip

Phone h-__________ work-__________ cell-__________

Email ______________________________

Sex: ☐ M ☐ F Age ___ Birthdate ______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# ______________________________

Occupation ______________ work # ______________

Employer ______________________________

Employer Address ______________________________

Employer Phone ______________________________

Spouse's Name ______________________________

Birthdate ______________ SS# ______________

Occupation ______________________________

Spouse's Employer ______________________________

Reason for today's visit ______________________________

Former Dentist ______________________________

City/State ______________________________

Date of last dental visit ______________________________

Date of last dental X-rays ______________________________

Any complications following dental treatment ☐ Yes ☐ No Please explain ______________________________

Date: ______________________________

DENTAL INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Company ______________________________

Group # ______________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________ I hereby authorize Grand Canyon Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

______________________________ ______________

Relationship Date

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________________ Relationship ______________________________

Home Phone ______________________________ Work Phone ______________________________

HIPPA - I have read this consent form and agree.

Do we have permission to leave messages on your home or cell phone? ☐ Yes ☐ No

Signature ______________________________ **Date** ______________

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. I understand that I am financially responsible for all charges whether or not my insurance pays. Signature ______________________________ **Date** ______________

Any appointment that is cancelled or broken without 24 hours notice, will be charged $35.00

File and/or X-ray duplication fees are $19.00.

Payment is due at the time of treatment. We accept cash, check, and major credit cards.

We also offer a payment plan called Care Credit. Ask for a brochure today!

______________________________ Date: ______________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other ______________

Name of person or office referring you to our practice: ______________________________

-- OVER --

Proforma Quality Imaging 928-708-9928

HEALTH HISTORY

Physician's Name ______ Dr. Phone: ______ Date of last visit ______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition		
Abnormal Bleeding	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
AIDS	☐ Yes	☐ No	Epinephrine Allergy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Hepatitis- Type____	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Cardiovascular Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Teeth Grinding/Clenching	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Jaw Pain/TMJ/TMD	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
			Macular Degeneration	☐ Yes	☐ No			
Diabetes Type I or II	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, Sudden	☐ Yes	☐ No

Fear of dental work? Interested in light sedation? ☐ Yes ☐ No

Are you taking any bisphosphonate medications? ☐ Yes ☐ No

Do you have any other condition or major surgery not listed above? ☐ Yes ☐ No

If yes, please explain : ______

Women:
Are you pregnant? ☐ Yes ☐ No
Due Date_____
Are you nursing? ☐ Yes ☐ No

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______

MEDICATIONS

List medications you are currently taking: Date:

______

Pharmacy Name ______

Phone ______

UPDATE MEDS:

Date:

______

ALLERGIES

☐ **Aspirin**
☐ **Barbiturates** (Sleeping Pills)
☐ **Codeine**
☐ **Iodine**
☐ **Latex**
☐ **Local Anesthetic**
☐ **Penicillin**
☐ **Sulfa**
☐ **Other** ______

I will update my dental office regarding any changes to my health.

______ Date: ______

Signature of patient, parent or guardian

M.H. & B P Updates:

For office use only

Date: ______ Dr. int. ______

Date: ______ Dr. int. ______

Date: ______ Dr. int. ______

Date: ______ Dr. int. ______

Date: ______ Dr. int. ______