250 S Fuller St.
Shakopee MN 55379

952-445-6657
Fax:952-445-0674
pam@obriendentalcare.com

Patient Name:_____
Last First M Preferred Name

Title:_____ ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/ect

Birth Date:_____ SS:_____

Email Address:_____ Best way to reach you:_____

Phone: _____ _____ _____ _____
Home Work Mobile Fax

Address:_____

_____
City State Zip Code

Patient Employer Position Employer Phone Number

If Minor/Father Birth date Employer/Position Employer Phone Number

If minor/Mother Birth date Employer/Position Employer Phone Number

Emergency Contact Information

Prior Dentist's name, address phone number, and DATE OF LAST XRAYS, CLEANING AND EXAM

Insurance Information

Name of Insured: _____
Last First MI

Patient's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insured Employer

_____

Insured's Birthday ID# Group # Insurance Phone Number

_____

Do you have Secondary Insurance? ☐ Yes ☐ No

Name of Person, office or other source referring you to our practice:

_____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on half of my dependents.

I understand that finance charges of 1.5% monthly of 18% annually accrue on my account after 60 days. In the event I default of payments and collection action is initiated, I will take full responsibility for any charges for collection fees and/or attorney fees.

Medical History Form

Current Medications
(Including if you've ever taken medications for osteopenia or osteoporosis, such as Actonel, Boniva, Fosamax)

Are you allergic to LATEX? ☐ Yes ☐ No

Are you allergic to any medication? ☐ Yes ☐ No
If YES please list

Please indicate if you have ever experienced any of the following:

☐ Artificial Joints	☐ Asthma	☐ Cancer _____
☐ Diabetes	☐ Epilepsy	☐ Excessive Bleeding
☐ Glaucoma	☐ Heart Disease	☐ Heart Murmur
☐ Heart Pacemaker	☐ Heart Surgery	☐ Hepatitis
☐ High Blood Pressure	☐ HIV positive/AIDS	☐ Rheumatic Fever
☐ Tuberculosis	☐ Snoring	☐ Sleep Apnea

Are you pregnant: ☐ Yes ☐ No Do you use tobacco: ☐ Yes ☐ No

List any previous surgeries and approximate dates

Your Primary Care Physician's Name and/or Name of Clinic and Location

If you have any other health concerns we need to know or you are currently under the care of a physician for a specific condition not listed, if so please explain

Have you ever been told to take an antibiotic or premedication prior to dental treatment?
☐ Yes ☐ No

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) CONSENT FOR USE AND DISCLOSERE OF HEALTH INFORMATION

SECTION A: Patient giving consent

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENT CAREFULLY
Purpose of consent: By singing 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 PRACTIVES: You have the right to read our Notice of Privacy Practices before you decide 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 by contacting:
O'Brien Dental Care
250 S Fuller St.
Shakopee, MN 55379
952-445-6657

I understand that unless I state otherwise, O'Brien Dental Care may contact me using any forms of communication that I provide to them, including phone numbers, email addresses, and text messages.

Our Practice may disclose protected health information for treatment, payment, and health care operations to another healthcare provider or insurance company as needed and covered under HIPAA using Electronic Communication.

We may disclose protected health information if the patient is able to agree to or if the patient is incapacitated and it is in his or her best interest. This includes if a friend or family member accompanies the patient to an appointment and the patient allows them to be in the treatment area or if they accompany a minor to their appointment.

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 listed above. Please understand the revocation of this Consent will affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue to treat you if you revoke this Consent.

I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. Please understand that by choosing to accept the Consent form, I am giving my consent to your use and disclosure of my protected health information. Check yes if you accept this consent, check no if you decline.

☐ Yes ☐ No

In order for us to provide you the best care, we would like to know what brought you in today. Please indicate the reason for your visit below and if you wish, place a mark by any procedure or service you would like to hear more about today.

- ☐ Cleaning and Comprehensive Exam
- ☐ Tooth Pain
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ TMD/ Jaw Pain
- ☐ Bad Bite
- ☐ Headaches/Migraines
- ☐ Dental Implants
- ☐ Dentures/Partial Dentures
- ☐ Missing Teeth
- ☐ Cosmetic Dentistry
- ☐ Veneers
- ☐ Invisalign
- ☐ Teeth Whitening
- ☐ Botox
- ☐ Juvederm
- ☐ Radiesse
- ☐ Other_____

O'BRIEN | DENTAL CARE

AUTHORIZATION TO RELEASE DENTAL RECORD INFORMATION

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

I authorize: _____to release my Dental Records to:
(Previous Dental Office)

Obrien Dental Care
250 S Fuller St.
Shakopee, MN 55379
Phone: 952-445-6657
Fax: 952-445-0674
Email: pam@obriendentalcare.com

Please release the following documentation:
_____X-Rays
Other: _____

Patient Signature:_____ Date: _____

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED