O'BRIEN DENTAL CARE

Patient Name_____ Birth Date_____

Family Status ☐ Married ☐ Single ☐ Child ☐ Male ☐ Female

Address with Zip Code_____

Cell Phone #_____ Home Phone #_____

Work Phone #_____ Email_____

SSN:_____ Employer_____

If Minor/ Mothers Name and Phone Number_____

If Minor/ Fathers Name and Phone Number_____

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

_____

_____

Allergies to Medications ☐ Yes ☐ No **Latex Allergy** Yes ☐ No ☐
(Please list below)

_____

_____

Have you ever been told by your primary care physician to take an antibiotic or premedication prior to dental treatment? ☐ Yes ☐ No

Please indicate if you have ever experienced any of the following (Please circle all that apply)

Artificial Joints	Osteoporosis	Diabetes	Asthma	Hepatitis
Heart Surgery	Abnormal Bleeding	Epilepsy	Glaucoma	Rheumatic Fever
Heart Disease	High Blood Pressure	Kidney Disease	Tuberculosis	HIV Positive/AIDS
Heart Murmur	Stroke	Radiation	Headaches	Clenching/Grinding
Cancer	Pacemaker	Sleep Apnea	Jaw Pain	

Are you pregnant or nursing? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

List any previous surgeries and approximate dates:

_____

_____

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

_____

_____

Insurance Information

Policy Holder's Name_____ Birth Date_____

Policy Holders Employer_____

Insurance Company Name and Phone Number_____

ID Number_____ Group Number_____

Patients Relationship to policy holder_____

Patient Treatment Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality of dental care, so that you may attain optimal oral health.

As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums, which are your responsibility. Please contact your insurance company for all details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you as our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

We ask that you pay the deductible, co-payment and co-insurance, which is an estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover or CareCredit at the time we provide the service to you.

I understand that I am responsible for all charges including those that insurance does NOT cover.

Patient Signature:_____ Date:_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our full Notice of Privacy Practices before you decide to sign this Consent. A copy will be made available to you at your request. Our notice provides a description of our treatment, payment activities and health care operations, and the use of and disclosures we may make of your protected health information.

We reserve the right to change our privacy practices as described in our notice. If this happens 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 by contacting:

O'Brien Dental Care
250 Fuller St. South
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 postal mail, 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 family member or friend 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 have the right to revoke this consent at any time by giving us written notice of your revocation to the contact listed above. Please understand the revocation of this consent will affect any actions we took before receiving your revocation.

I have had the full opportunity to read and consider the contents of the Consent for and Notice of Privacy Practices. I understand that by choosing to accept the Consent form I am giving my consent to your use and disclosure of my protected health information.

Patient Signature:_____ Date:_____

O'BRIEN | DENTAL CARE

In order for us to provide you with the best care, we would like to know what brings you in today. Please indicate the reason for your visit below by placing a mark next to the 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
- ☐ Dentures/Partial Dentures
- ☐ Implant Supported Dentures
- ☐ Missing Teeth
- ☐ Cosmetic Dentistry
- ☐ Veneers
- ☐ Invisalign
- ☐ Teeth Whitening
- ☐ Botox
- ☐ Juvederm
- ☐ Radiesse
- ☐ Other _____

O'Brien Dental Care
obriendentalcare.com
250 Fuller St S
Shakopee, MN 55379

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 my dental records to be released to O'Brien Dental Care.

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

_____

_____

Please send the following documentation:

_____X-Rays

_____CT Scan

_____Other

O'Brien Dental Care
250 Fuller St. South
Shakopee, MN 55379
Phone: 952-445-6657
Fax: 952-445-0674
Email: pam@obriendentalcare.com

Patient Signature:_____ Date:_____

This authorization expires one year after it is signed.