CedarCreek DENTAL

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I was offered a copy of this office's notice of Privacy Practices and a copy will be provided in the future upon my request.

_____
{Please Print Name}

_____
(Signature) (Signature of parent or guardian if minor)
July 28, 2023

This portion of the form is used to identify the family members, close friends, or other persons to whom we may disclose protected health information about you or notify regarding your care. This form is effective for the duration of your care or until you provide further written notice.

Name:_____ Relationship to patient:_____
Telephone:_____

Name:_____ Relationship to patient:_____
Telephone:_____

Name:_____ Relationship to patient:_____
Telephone:_____

_____**For Office Use Only**_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (specify)

Patient Information Update

Please take a few minutes to review the following information, make any necessary changes, and answer the questions completely. If you provide us with an e-mail address that you check frequently, we'll send appointment reminders to you electronically.

If you are new to our office, who may we thank for referring you_____

Name:
Address:

Home phone:
Work phone:
Cell phone/pager:
e-mail:

DOB:

Occupation: _____
Spouse's Name:_____

Place of Employment:_____
Any change in your marital status? (If so,what?)_____

Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed.

	Primary coverage	Secondary coverage
Insured Party:		
Employer/plan:		
Insurance company:		

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/ or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____
Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____
Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date

Medical History / Information

Emergency contact, **other than spouse**:_____
Relationship:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Medical Doctor:_____ City / Phone:_____

Allergic to: ___ Latex ___ Codeine ___ Antibiotics (list below)

Please List ***All Other Allergies*** to Medications or Other:_____

_____

List all medications you are currently taking, and why you are taking them:_____

_____

Are you taking or have you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa?_____

Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? **Y / N**

Please list any *Surgeries or Hospitalizations* you have had in the past 5 years:_____

_____

Are you pregnant or nursing? **Y / N** (Due date: _____) Are you taking birth control pills? **Y / N**

Patient Information Update (p.2)

Patient:

Do you use nicotine? **Y/N** Type: Smoke/chew/dip/Ecigs/Vape How often? _____ For how many years:___

Please circle, if you experience Headaches / Back pain / Neck pain: How often?_____ Severity? _____

Is there anything you want to talk to the doctor about today? _____

_____

Do you have or have you had any of the following conditions? (Circle Y or N)

Y N Heart attack/stroke	Y N Thyroid problems	Y N Cancer or Tumors
Y N Cosmetic Surgery	Y N Heart Surg./ Pacemaker	Y N Kidney Problems
Y N Shingles	Y N Xray or Cobalt Treatment	Y N Infectious Endocarditis
Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Abnormal Heart Condition	Y N Respiratory Problems	Y N HIV / AIDS / ARC
Y N Asthma	Y N Allergy or Hives	Y N Sinus Problems
Y N Arthritis/ Rheumatism	Y N Organ Transplant	Y N Artificial Heart Valves
Y N Stomach Problems/Ulcers	Y N Artificial Bones/ Joints	Y N Diabetes
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema
Y N Leukemia	Y N Congenital Heart Defect	Y N Difficulty Breathing
Y N Fainting/ Seizures/ Epilepsy	Y N Anemia	Y N Chest Pains
Y N Alcohol/ Drug Abuse	Y N Glaucoma	Y N High Blood Pressure
Y N Eating Disorder	Y N Tuberculosis (TB)	Y N Hypoglycemia
Y N Bleeding Problems	Y N Nervousness	Y N Sleep Apnea

Please list any other medical conditions not listed:_____

_____

_____

The above information is true.

The undersigned hereby authorizes the Doctors and Staff of Dental Associates of Cedar Creek 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 the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% 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 affect collection of this note.

Signature:_____ Date: July 28, 2023

Please check one: __Adult patient __Parent or Guardian __Spouse

For office use only: Entered into computer by (initials): _____ *Date:* _____

Last prophy: BWX: FMX: Pano: