HIPAA Form

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Section A : Patient giving Consent

Patients First Name *

Patients Last Name *

Section B: 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 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.

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 Dr. Austin Meyer. 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.

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 healthcare operations.

☐ I am signing on behalf of the patient

Signature *

Today's Date

09/06/2023

Medical History

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Austin Meyer D.D.S. Inc.

Eaglesoft Medical History

Time

12:02 PM

DATE *

09/06/2023

Patient's First Name *

Patient's Last Name *

Birth Date *

MM/dd/yyyy

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?

○ Yes ○ No

Have you ever been hospitalized or had a major operation?

○ Yes ○ No

Have you ever had a serious head or neck injury?

○ Yes ○ No

Are you taking any medications, pills, or drugs?

○ Yes ○ No

When was your last dental visit?

MM/dd/yyyy

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

Do you use tobacco?

○ Yes ○ No

Do you use controlled substances?

○ Yes ○ No

Women: Are you...

○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other?

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Do you have, or have you had, any of the following?

AIDS/HIV Positive

○ Yes ○ No

Radiation Treatments

○ Yes ○ No

Alzheimer's Disease

○ Yes ○ No

Diabetes

○ Yes ○ No

Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis A, B or C ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Hypoglycemia ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Allergies (seasonal) ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No
Parathyroid Disease ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Anxiety/Derpression ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
ADD/ADHD ◯ Yes ◯ No	Bacterial Endocarditis ◯ Yes ◯ No		Blood Thinner ◯ Yes ◯ No

Have you ever had any serious illness not listed above?

◯ Yes ◯ No

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature *

Date *

09/06/2023

New Patient Information

Patient Information

Date

09/06/2023

Patient's Last Name *

Patient's First Name *

MI

_

○ Married ○ Single ○ Minor

○ Male ○ Female

Social Security #

___-__-____

Birth Date *

MM/dd/yyyy

Address *

Street

Apt #

City *

State *

__

Zip Code *

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Name of Employer

Address

City

State

__

Zip Code

_____

If Full Time Student, School Name

Grade

Person Responsible for Account

○ Patient ○ Guardian ○ Spouse ○ Father ○ Mother

Insurance Information

Minor Child - May need to complete both block for Parent Information
Adults - Complete Primary Insured
Dual Coverage? Also complete Secondary Insured

Primary Insured
If no Insurance, Complete for Responsible Party

Last Name

First Name

MI

_

Address

Street

City

State

__

Zip Code

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Birth Date

MM/dd/yyyy

Relationship To Patient

Employer

Dental Insurance Company

Social Security #

___-__-____

Subscriber #

Group #

Secondary Insured

Last Name

First Name

MI

_

Address

Street

City

State

__

Zip Code

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Birth Date

MM/dd/yyyy

Relationship To Patient

Employer

Dental Insurance Company

Social Security #

___-__-____

Subscriber #

Group #

Person to Contact In Case of Emergency

Name

Address

City

State

__

Zip Code

_____

Telephone #

(___) ___-____

Has any member of your family ever been treated in our office?

○ Yes ○ No

Whom may we thank for referring you to our office?

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I gran the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Patient or Responsible Party *

Date

09/06/2023

Drivers License #

State

—

Method of Payment

Responsible Party currently has an account with this office?

○ Yes ○ No

☐ Payment in full at each appointment

☐ I wish to discuss the Dental Office's Financial Policy

Service Charge

If I do not pay the entire new balance within

days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of

% per month

or a minimum charge of

$

for the balance under

$

which is an annual percentage rate of

%

applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or Responsible Party *

Date

09/06/2023

Patient Confidentiality

PATIENT CONFIDENTIALITY

If you wish others to receive information regarding your care, you must sign this release. By signing this, you are giving the team at our office, permission to release information to others. If you would like us to release information to someone other than insurance companies, specialists, etc. Please list their names /relationship to you and telephone number.

Name	Relationship	Phone #

Patient's First Name *

Patient's Last Name *

Patient's Signature *

Date *

09/06/2023