

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 If yes, please explain: _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
 Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
 Do you take, or have you taken, Phen-Fen or Redux? Yes No
 Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No
 Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No
 Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SILVER SCREEN DENTAL POLICIES

It is of the utmost importance to our patients and our staff that all appointments run on-time. One appointment that runs late can cause a domino effect for all following appointments. In order to be a conscientious patient we have the following policies:

- We require that all patients give **AT LEAST 2 working day's** notice to change an appointment time; that allows time to fill that appointment with someone from our waiting list.
- Patients that are unable to give us proper 2 working day's notice to change an appointment time will from then on be required to give a **\$75 non-refundable credit card deposit** for future appointments.
- Tardiness can result in an automatic cancellation. It is YOUR responsibility to let us know if you are running late.
- Not showing up to an appointment is inconsiderate to both our staff and to the other patients. With adequate warning we will be able to provide care to other patients who are on our waiting list.
- Any appointments that run over **1 ½ hours** will require a **prepayment** or a **non-refundable** deposit. This includes same day family appointments.

These simple policies help ensure that our office runs efficiently and in-turn enables you to be seated and treated with the proper amount of time.

FINANCIAL AGREEMENT

Silver Screen Dental will file my insurance as a courtesy and usually requires only my **estimated** payment at the time of treatment. I understand that Silver Screen Dental is not contracted with any insurance company (not in any networks) and payment is due when services are rendered unless prior financial arrangements have been made. Differences between the **estimated** amount and the amount paid by insurance will be billed to me. I am ultimately responsible for any charges that my insurance does not pay. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that FINANCE CHARGES will be applied to all accounts over 90 DAYS PAST-DUE regardless of outstanding/unpaid insurance claims. (This means that all balances must be paid off by you in order to avoid charges; any applicable insurance money will be reimbursed to you later.)

Any appointments that run over **1 ½ hours** will require a **prepayment** or a **non-refundable** deposit. This includes back-to-back family appointments.

PAYMENT PLAN OPTIONS

- We accept CareCredit & other outside financing options that offer **LOW PAYMENT** or **NO INTEREST** plans.
- We offer a **5% SENIOR CITIZEN DISCOUNT** to patients 65 and over.
- We offer a **5% discount for full prepayment** on all treatment plans over \$2000 (cash or check only). Payment must be paid in full prior to treatment with the understanding that any applied insurance will be reimbursed to you later.

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

Please do not discuss my medical or payment information with anyone

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the HIPAA Consent form.

Signature & Date