Hightower dental concepts
Compassionate Family Dentistry

Patient Acquaintance Form

Name: _____ Address: _____

City: _____State: _____Zip: _____Home Phone: _____

Work Phone: _____ Cell: _____

Birthdate: _____/_____/_____ Sex: (M /F) Social Security #: ____-_____-_____ Marital Status: ____

E-mail:_____

Insurance Coverage (Y/N)

Name of Insured _____

Date of Birth of Insured: ___/____/_____ Social Security of Insured: ____-_____-_____

Employer Name: _____

Referred By: _____

Medical History

(Yes/No) Are you allergic to any drugs or medications? If yes, please list_____

(Yes/No) High blood pressure? If yes, please list medication: _____

(Yes/No) A heart ailment, including mitral valve prolapse or heart murmur? _____

(Yes/No) Do you have a history of heart surgery? If yes, please list: _____

(Yes/No) Do you have Diabetes?

(Yes/No) Do you have Rheumatic fever?

(Yes/No) Do you have HIV or AIDS? If yes, please list medication: (Yes/No) (Yes/No)

_____

(Yes/No) Do you have Hepatitis? If yes, please list type: _____

(Yes/No) Have you ever had any radiation treatment?

(Yes/No) Do you have epilepsy, convulsions, or seizures?

(Yes/No) Do you have any pain in or near your ears?

(Yes/No) Are you pregnant? If yes, how many months?_____.

Are there any other conditions we should be aware of? _____

Are you presently taking drugs or medications not listed above for any other medical condition? If yes, please list: _____

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Dental History

Do you have or have you ever had any of the following: Please circle.

Bleeding, sore gums	(Yes/ No)
Clenching/grinding?	(Yes/ No)
Clicking/popping jaw?	(Yes/ No)
Sensitive teeth (hot or cold)?	(Yes/ No)
Teeth sensitive to sweets?	(Yes/ No)
Orthodontic treatment (braces)?	(Yes/ No)
Deep cleanings (Scaling/root planning)	(Yes/ No)

Do you use the following? Please circle.
(Yes/No) Toothbrush How often? _____ Manual or Electric?
Toothbrush type is: (Soft) (Medium) (Hard)
(Yes/No) Dental Floss? How often_____

Is there anything about your teeth you would like to change? _____
Do you want whiter teeth? _____

In case of emergency, notify: _____ Phone Number: _____

Unless prior arrangements have been made, payment is expected at time of service.
In order to provide the best possible service, please notify us at least 24 hours in advance if you are not able to keep an appointment. Broken appointments will be subjected to a charge.

I certify that the above information is true and accurate to the best of my knowledge. I accept full financial responsibility for my account, including any fees which are assessed to my account to collect any outstanding balance.

_____ _____
Signature Date

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COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.
A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.
It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____	_____	_____
Signature	Print Name	Date

Appointment Confirmation/Cancellation Policy

We strive to provide the most compassionate family dental care to our patients. When an appointment is scheduled, that time has been reserved for you and when it is missed, that time cannot be used to treat another patient.
Our Policy is as follows: Patients are required to confirm their appointment **48 hours** in advance through verbal verification, text verification or email at hdconcepts01@gmail.com. Unconfirmed appointments are subject to being rescheduled. Cancellations will require a 48-hour notice.

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Acknowledgement of receipt of notice of privacy practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

Authorization to release specific protected health information

Per your request we are allowed to fax dental excuses to your school or business

_____
Please print name

_____
Signature

_____
Date

For office use only

We attempted to obtain acknowledgement of receipt of our notice of privacy practices, but acknowledgement cannot be obtained because:

___ Individual refused to sign
___ communications barriers prohibited obtaining acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)

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Insurance Information Form

As a courtesy to you, we do accept copayments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Regardless of what we might calculate as your copayment you are responsible for the TOTAL TREATMENT FEE. The estimate we make is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

I authorize Leah Larson, D.D.S. and Kris Fernandez, D.D.S. to release any information including diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or parent if minor Date