



**EDINBURGH
FAMILY
DENTISTRY**

Creating Beautiful Smiles With A Personal Touch

HIPPA CONSENT FORM

Edinburgh Family Dentistry
Joshua H. Curling, DDS
200 Carmichael Way Suite 600
Chesapeake, VA 23322
757-204-7210

Patient Name: _____

Patient Phone #: _____

HIPPA – Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Edinburgh Family Dentistry may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Edinburgh Family Dentistry has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer: Suzanne Robusto.

I hereby acknowledge that I have received a copy of Edinburgh Family Dentistry Notice of Privacy Practices.

Initials of patient/guardian

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to: _____

Name/Relationship

Initials of patient/guardian

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by Vibrant Dental to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Edinburgh Family Dentistry for participating health insurance plans.

Signature of Patient/Guardian

Date



INSURANCE VERIFICATION SHEET

Patient Name: _____

Employer: _____ Carrier: _____

NEIC #: _____ Group #: _____

Indemnity PPO Flat Fee We Participate: YES NO
Delta: Premier Preferred United Concordia: NFFS ParNet

Renewal Month: _____ Prevent: _____% Waiting Period: _____
Annual Max: _____ Basic: _____% Waiting Period: _____
Individual Ded: _____ Endo: _____% Waiting Period: _____
Family Ded: _____ Perio: _____% Waiting Period: _____
Lifetime Ded: _____ Surg: _____% Waiting Period: _____
Ded on Prev Proc: _____ Major: _____% Waiting Period: _____
Dep Child Thru Age: _____ Sealants: _____% Waiting Period: _____
Full Time Student: _____ Space Maint: _____% Waiting Period: _____

PREVENTATIVE

Prophy/Exam: 2 per calendar year 6 months apart 1 or 2 per 12 consecutive months
Flouride thru age: _____ 1 or 2 per calendar year 6 months apart 1 or 2 per consecutive months
Bitewings: 1 or 2 per calendar year 6 months apart 1 or 2 per 12 consecutive months
FMX/Pan (either/or): 1 every _____ years or _____ consecutive months
Sealants thru age: _____ Frequency Limits: _____ Specifics: _____
Emergency Exam: _____ Emergency Tx (9110): _____% Specifics: _____
Extra Benefit for prophy for Pregnancy: Y N Diabetics: Y N Heart Problems: Y N
Perio Evaluation (D0180): Count toward limit of exams? Y N Specifics: _____

BASIC

4355 Covered: Y N Replace regular prophy? Y N Requirements: _____
4910 Covered: Y N Replace regular prophy? Y N Requirements: _____
Quad Scale Covered: Y N _____ Quads per day Freq Limit: _____ X-ray/Perio Chart Req: Y N
4342 Same Day as regular prophy: Y N Specifics: _____ Oral Cancer Test: _____
Arestin Covered: Y N Freq. Limit _____ Same Day as 4341/4342: Y N XR/Perio Cht? Y N
Posterior Composites Covered: Y N Downgraded to amalgam? Y N
Surgical Extractions covered at: _____% File under Dental: _____ File under Medical: _____
Space Maintainers: _____

MAJOR

File on Prep Date: _____ File on Seat Date: _____ X-ray required for single crown? Y N
Waiting Period: Y N Specifics: _____
Missing Tooth Clause: Y N Specifics: _____
Single crowns covered: _____% _____ yr replacement policy Pre-authorization Required: Y N
_____ Replacement policy on partials/bridges/dentures Veneers: _____
Implants Covered: Y N Crowns to cover implants covered: Y N Specifics: _____
Pre-Authorization required for major? Y N
Night Guards: Brux: Y N TMJ: Y N Specifics: _____

Effective Date of Policy: _____ Amt Remaining on Balance: \$ _____ Deductible Met? Y N
X-Ray History: FMX/PAN _____ Bitewings: _____ Exam: _____
COB: Standard: _____ Birthday Rule: _____ Non Duplicating: _____
Carrier Address: POB: _____ Street: _____
City: _____ State: _____ Zip: _____ Phone #: _____
Verified by: _____ Date: _____ Insurance Rep: _____

Medical History

Patient:

PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Date of Last Visit _____ Date of Last

Cleaning _____

(Please circle each)

- | | | | |
|-----|--|-----|------------------------------------|
| Y N | I clench or grind my teeth during the day or while sleeping. | Y N | I have problems eating. |
| Y N | My gums bleed while brushing or flossing. | Y N | I have dental anxiety. |
| Y N | I like my smile. | Y N | I have had a facial or jaw injury. |
| Y N | I prefer tooth-colored fillings. | Y N | I want my teeth straight. |
| Y N | I avoid brushing part of my mouth due to pain. | Y N | I want my teeth whiter. |
| Y N | My gums feel tender or swollen. | | |

What are your dental priorities? _____

PATIENT'S MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? Please circle Y for yes or N for no.

- | | | | | | |
|-----|---|-----|---|-----------------------------|--|
| Y N | Heart Disease | Y N | Liver Disease | Y N | Glaucoma |
| Y N | Heart Murmur/Mitral Valve Prolapse | Y N | Jaundice | Y N | Kidney Disease |
| Y N | Cardiac Bypass Surgery: Year _____ | Y N | Hepatitis Type _____ | Y N | Epilepsy/Seizures |
| Y N | Stroke | Y N | Herpes | Y N | Arthritis |
| Y N | Congenital Heart Lesions | Y N | Ulcers (mouth) | Y N | Hearing Loss |
| Y N | Rheumatic Fever | Y N | Cold Sores | Y N | Immune Suppressed Disorder |
| Y N | Abnormal Blood Pressure | Y N | Asthma | Y N | AIDS |
| Y N | Anemia | Y N | Sinus Trouble | Y N | Sexually Transmitted /Venereal Disease |
| Y N | Prolonged Bleeding Disorder | Y N | Fainting Spells | | <u>WOMEN</u> |
| Y N | Tuberculosis or Lung Disease | Y N | Tumor or Malignancy | Y N | Are you taking birth control medication? |
| Y N | History of Drug Addiction | Y N | Radiation Treatment | Y N | Are you or could you be pregnant ? |
| Y N | History of Emotional or Nervous Disorders | Y N | Cancer/Chemotherapy: Type _____ Year _____ | | |
| Y N | Excessive Urination and/or Thirst | Y N | Diabetes: Type I / Type II | How is it controlled? _____ | |
| Y N | I have taken Fen-Phen or Redux | Y N | I usually take an antibiotic prior to dental treatment. | | |
| Y N | Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other _____ | | | | |
| Y N | I smoke or use tobacco. Type _____ | | | How much per day? _____ | |
| Y N | I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____ | | | | |
| Y N | Do you have any other medical problem or medical history NOT listed on this form? _____ | | | | |

Are you allergic to any of the following?

- | | | | | | |
|-----|-------------------------------|-----|-------------------------------|-----|-------------------------|
| Y N | Aspirin | Y N | Penicillin | Y N | Codeine |
| Y N | Ibuprofen | Y N | Sulfa Drugs/Sulfites/Sulfides | Y N | Latex, Metals, Plastics |
| Y N | Local Anesthetics (Novocaine) | Y N | Other Medications: _____ | | |

Please list all medications you are currently taking:

Medication _____	Condition _____	Medication _____	Condition _____
Medication _____	Condition _____	Medication _____	Condition _____
Medication _____	Condition _____	Medication _____	Condition _____

Physician's Name _____ Phone _____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ Date _____ X _____ Date _____
 Doctor's Signature Patient's or Parent/Guardian's Signature

Periodic medical/dental health reviewed by:

X _____ Date _____ X _____ Date _____
 Doctor's Signature Patient's or Parent/Guardian's Signature

Patient Information

PATIENT

Name _____ Nickname _____ Sex _____
 Birthdate _____ Soc Security No _____ Driver's License # and
 State _____
 Email _____ Marital Status _____
 Phone: Home (____) _____ Work (____) _____ Cell
 (____) _____
 Home Address _____ City, State, Zip

 Pri Insurance _____ Group _____ Subscriber _____
 Sec Insurance _____ Group _____ Subscriber _____

POLICY HOLDER INFORMATION

Name _____ Phone: Home (____) _____ Work
 (____) _____
 Soc Security No _____ Birthdate: ____/____/____ Driver's License
 #/State _____
 Home Address _____ City, State, Zip

 Employer _____ Occupation _____
 Address _____ Business
 City, State, Zip _____

SPOUSE/PARENT/GUARDIAN

Name _____ Phone: Home (____) _____ Work
 (____) _____
 Home Address _____ City, State, Zip

 Employer _____ Occupation _____
 Address _____ Business
 City, State, Zip _____

REFERRAL

Who selected this Office? Self Spouse Parent Employer
 Where did you find the Phone Number to this Office?
 Referred by a friend Yellow Pages Relative Insurance Plan
 Internet Newspaper Ad Direct Mailing Sign by Building
 If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge _____ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date _____ Relationship to Patient _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.