Rebekah Walters Branscum
DENTISTRY

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

- Treatment (including director or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA I understand that you reserve the right to change the terms of this Notice form time-to-time and that I may contact you at any time to obtain the most current copy of this Notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, you use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing this, I understand the above information and agree with its contents.

Signature _____ Date _____

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DENTAL INSURANCE

Do you have dental insurance? Yes or No

If yes, please fill out the following, sign and date. If no, sign and date only.

Name of Insured _____ Insured's Date of Birth _____

Insured's Address _____

City _____ State _____ Zip _____

ID# _____ Group# _____

Insurance Company Phone Number _____

Insurance Address _____

City _____ State _____ Zip _____

Patient's Relationship to Insured _____

Insured's Employer Name _____

Employer's Address_____

City _____ State _____ Zip _____

Carrier Name _____ Plan Name _____

Do you have Secondary Insurance? Yes or No

If yes, please fill out the following, sign and date. If no, sign and date only.

Name of Insured _____ Insured's Date of Birth _____

Insured's Address _____

City _____ State _____ Zip _____

Patient's Relationship to Insured _____

Insured's Employer Name _____

Employer's Address_____

City _____ State _____ Zip _____

Carrier Name _____ Plan Name _____

ID# _____ Group# _____

Insurance Company Phone Number _____

Insurance Address _____

City _____ State _____ Zip _____

Signature _____ Date _____

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PATIENT INFORMATION

First Name _____ Last Name _____

What name does the patient prefer to go by? _____

Date of Birth _____ Gender _____ SSN _____

Email Address _____

Phone Number with Area Code Home _____ Mobile _____

Address _____

City _____ State _____ Zip _____

Who is filling out the form today? _____

How did you hear about us? _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Guarantor First Name _____ Guarantor Last Name _____

Relationship to Patient _____ Phone Number with Area Code _____

Address _____

City _____ State _____ Zip _____

EMPLOYMENT DETAILS

Occupation _____ How Long _____

Employer Name _____

Please list 2 contact names to whom practice can release PHI information (HIPAA)

Name _____ Phone Number _____

Name _____ Phone Number _____

EMERGENCY CONTACT

Name _____ Phone Number _____

Signature _____ Date _____

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MEDICAL HISTORY

Circle Yes Or No if you have any of the following allergies.

Aspirin Yes or No
Codeine Yes or No
Latex Yes or No
Local Anesthetic Yes or No
Penicillin Yes or No
Sulfa Yes or No
List any other allergies _____

Abnormal (High/Low) Blood Pressure Yes or No
Anemia/ Bleeding Problems Yes or No
Blood Disease Yes or No
Heart Problems Yes or No
Arthritis / Rheumatism / Gout Yes or No
Asthma Yes or No
Chemotherapy Yes or No
Emphysema Yes or No
Radiation Treatment (Xray/Cobalt) Yes or No
Sinus Trouble Yes or No
Thyroid Problems Yes or No
Tumor / Growth on Head / Neck Yes or No
Epilepsy Yes or No
Headaches (Frequent) Yes or No
Herpes Yes or No
Liver Disease Yes or No
Psychiatric Care Yes or No
AIDS/HIV Yes or No
Artificial Heart Valves Yes or No
Congenital Heart Lesions Yes or No
Pacemaker Yes or No
Artifical Joints / Bones Yes or No
Cancer Yes or No
Diabetes Yes or No
Glaucoma Yes or No
Shortness of Breath (Breathing Problems) Yes or No
Stroke Yes or No
Tuberculosis Yes or No
Ulcer Yes or No
Fainting / Dizziness Yes or No
Hepatitis Yes or No
Kidney Disease Yes or No
Nervous Problems Yes or No

List any other medical issues you have _____
_____

List any serious illnesses / surgeries / hospitalizations _____
_____

Are you taking any medications? Yes or No
List of medications you are taking _____
_____

Do you smoke? Yes or No
High Sugar Intake? Yes or No
Nursing? Yes or No
Do you drink alcohol? Yes or No
Pregnant? Yes or No
Is the patient under the care of a physician? Yes or No
Has the patient ever been hospitalized? Yes or No
Is the patient physically, mentally or emotionally impaired? Yes or No

Signature _____ Date _____

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CHILD DENTAL HISTORY (UNDER 18)

Is this your child's first dentist visit? Yes or No

Does your child have any of the following? Please circle Yes or No

Cavities / Decay Yes or No

Lip Sucking / Biting Yes or No

Speech Problems Yes or No

Nail Biting Yes or No

Pacifier / Thumb / Finger Sucking Yes or No

Mouth Breathing Yes or No

Tongue Thrust Yes or No

Nursing / Bottle Habits Yes or No

Jaw Problems Yes or No

Grinding Teeth Yes or No

Has the patient ever had orthodontic treatment (Braces) ? Yes or No

Has the patient ever had any pain / tenderness in their jaw join (TMJ / TMD) ? Yes or No

Signature _____ Date _____