Chalet Dental Care

Name _____ Birthdate _____
last first middle intial

Marital Status _____ Soc. Sec. No. _____ Phone Number _____

Residence Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Number _____

Employed By _____ Phone Number _____

May we call you at work? Yes No

Person Responsible for Account _____

Whom may we thank for referring you? _____

If you have insurance - either your own, your parent's or spouse's - which may assist you with a portion of your account, please complete the following:

Subscriber Name _____

Employer _____

Name of Insurance Company _____

Group # _____

Subscriber Soc. Sec. No. _____ Birthdate of Subscriber _____

Additional Coverage

Subscriber Name _____

Employer _____

Name of Insurance Company _____

Group # _____

Subscriber Soc. Sec. No. _____ Birthdate of Subscriber _____

When was the last time you visited a dentist and what was done? _____

_____

Were X-Rays taken? _____

Are your teeth sensitive? _____ Sweets? _____ Hot? _____ Cold? _____

Are you pleased with the appearance of your teeth? _____

Reason for appointment _____

Chalet Dental Care offeres a variety of services to our patients. Is there any of the following services you would like to know more about? Please check any of the following:

Snoring & Sleep Apnea. . . . . Do you snore or experience daytime drowsiness?

Botox Cosmetic . . . . . A safe, effective way to eliminate fine lines and wrinkles.

Invisalign. . . . . Straighten your smile the clear way. No braces needed. For all ages.

Dental Implants . . . . . Nothing replaces your natural teeth, but dental implants can come close.

Tooth Whitening . . . . . A simple, cost effective way to brighten your smile.

Veneers or Crowns . . . . . Enhance the appearance of your smile with Natural Looking Restorations.

over...

MEDICAL HISTORY

Patient Name: _____

Medical Doctor: _____ Phone Number: _____

Clinic or Location: _____

Notify Emergency: _____ Relationship to You: _____ Phone Number: _____

Check a definitive answer for each question:

Yes No Are you currently under the care of a physician? Describe treatment _____

Yes No Have you had any change in your health, any medical treatment or any physician visits this year? _____

Yes No Have you ever had any surgical operation of any kind? _____

Yes No Are you required to take a premedication prior to dental treatment? _____

Do you have, have you ever or have you been treated for any of the following?

Yes No Heart Murmur
Yes No Rheumatic Fever
Yes No Do you have mitral valve prolapse?
Yes No Cardiovascular disease (heart trouble, heart attack, stroke)
Yes No High Cholesterol?
Yes No Pacemaker (type) _____
Yes No High Blood Pressure
Yes No Low Blood Pressure
Yes No Anemia, Blood Disorders
Yes No Hemophilia, bleeding or blood disorders
Yes No Do you bruise easily?
Yes No Epilepsy, Seizures
Yes No Fainting Spells
Yes No Diabetes or Hypoglycemia
Yes No Asthma or Lung Problems
Yes No Tuberculosis
Yes No Hepatitis, Jaundice or Liver Disease
Yes No Kidney Disorder
Yes No Thyroid Condition
Yes No Ulcers
Yes No Arthritis
Yes No Depression
Yes No Anxiety/Nervous Disorder

Yes No Sleep Apnea/C-Pap
Yes No Osteoporosis
Yes No Are you or have you ever taken Bisphosphonates?
Yes No Chronic Sinus Problem
Yes No Oral Herpes, Cold Sores
Yes No Radiation/Chemotherapy When _____
Yes No AIDS or AIDS Related Complex (HIV)
Yes No Eating Disorder _____ specify
Yes No Chemical Dependency
Yes No Have you ever had an allergic reaction or been told not to take certain medication? _____
Yes No Allergies to anesthetics
Yes No Allergies to Latex rubber
Yes No Implants of any type or Joint replacement implant (type & year) _____
Yes No Are you pregnant? _____ Due Date: _____
Yes No Do you use any tobacco product? _____ Daily Use _____
Yes No Do you have any disease, condition or problem not listed? _____

Please list any over-the-counter or prescription medications you are taking:

Medication: _____ Dosage: _____

Patient's Signature _____ Date _____

CHALET DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name_____
Address _____

Telephone_____

TO THE PATIENT – 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 our 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 other important matters about your protected health information. A copy of our Notice of Privacy Practices 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. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

Privacy Officer
Telephone: 651-488-5888
1651 Dale St. N.
St. Paul, Minnesota 55117-3414

Consent Does Not Expire after One Year. By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. 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 continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

For Telephone, Text, Email Communications

□ **By checking this box, I consent to the following**: This Dental Practice or its service provider may contact me to provide health care information such as appointment reminders about treatment, payment, my insurance, my account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing. This Dental Practice may:

□ Call me □ Email me
□ Text me

SIGNATURE

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. 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 health care operations.

Signature_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name:_____
NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT