

WELCOME



**encore
DENTISTRY**
Nancy V. Cabansag, DDS

PATIENT INFORMATION

First Name: _____ Middle Initial: _____
Last Name: _____ Preferred Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Work Phone: _____
Sex: Male Female
Marital Status: Married Single Divorced Separated Widowed
Date of Birth: _____ Social Security Number: _____
Email: _____

PHARMACY INFORMATION

Preferred Pharmacy Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

HOW DID YOU HEAR ABOUT US?

Web Search Kroger Carts
 Family/Friend Smile America
Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: _____

MEDICAL HISTORY



**encore
DENTISTRY**

Nancy V. Cabansag, DDS

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 _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you **Pregnant?** Yes No **Taking Oral Contraceptives?** Yes No **Nursing?** Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following? **(Please only mark what applies)**

- | | | | |
|---|---|---|--|
| AIDS <input type="radio"/> / HIV Positive <input type="radio"/> | Cortisone Medicine <input type="radio"/> | Hemophilia <input type="radio"/> | Radiation Treatments <input type="radio"/> |
| Alzheimer's Disease <input type="radio"/> | Diabetes <input type="radio"/> | Hepatitis A <input type="radio"/> | Recent Weight Loss <input type="radio"/> |
| Anaphylaxis <input type="radio"/> | Drug Addiction <input type="radio"/> | Hepatitis B or C <input type="radio"/> | Renal Dialysis <input type="radio"/> |
| Anemia <input type="radio"/> | Easily Winded <input type="radio"/> | Herpes <input type="radio"/> | Rheumatic Fever <input type="radio"/> |
| Angina <input type="radio"/> | Emphysema <input type="radio"/> | High Blood Pressure <input type="radio"/> | Rheumatism <input type="radio"/> |
| Arthritis/Gout <input type="radio"/> | Epilepsy or Seizures <input type="radio"/> | High Cholesterol <input type="radio"/> | Scarlet Fever <input type="radio"/> |
| Artificial Heart Valve <input type="radio"/> | Excessive Bleeding <input type="radio"/> | Hives or Rash <input type="radio"/> | Shingles <input type="radio"/> |
| Artificial Joint <input type="radio"/> | Excessive Thirst <input type="radio"/> | Hypoglycemia <input type="radio"/> | Sickle Cell Disease <input type="radio"/> |
| Asthma <input type="radio"/> | Fainting Spells/Dizziness <input type="radio"/> | Irregular Heartbeat <input type="radio"/> | Sinus Trouble <input type="radio"/> |
| Blood Disease <input type="radio"/> | Frequent Cough <input type="radio"/> | Kidney Problems <input type="radio"/> | Spina Bifida <input type="radio"/> |
| Blood Transfusion <input type="radio"/> | Frequent Diarrhea <input type="radio"/> | Leukemia <input type="radio"/> | Stomach/Intestinal Disease <input type="radio"/> |
| Breathing Problem <input type="radio"/> | Frequent Headaches <input type="radio"/> | Liver Disease <input type="radio"/> | Stroke <input type="radio"/> |
| Bruise Easily <input type="radio"/> | Genital Herpes <input type="radio"/> | Low Blood Pressure <input type="radio"/> | Swelling of Limbs <input type="radio"/> |
| Cancer <input type="radio"/> | Glaucoma <input type="radio"/> | Lung Disease <input type="radio"/> | Thyroid Disease <input type="radio"/> |
| Chemotherapy <input type="radio"/> | Hay Fever <input type="radio"/> | Mitral Valve Prolapse <input type="radio"/> | Tonsillitis <input type="radio"/> |
| Chest Pains <input type="radio"/> | Heart Attack/Failure <input type="radio"/> | Osteoporosis <input type="radio"/> | Tuberculosis <input type="radio"/> |
| Cold Sores/Fever Blisters <input type="radio"/> | Heart Murmur <input type="radio"/> | Pain in Jaw Joints <input type="radio"/> | Tumors or Growths <input type="radio"/> |
| Congenital Heart Disorder <input type="radio"/> | Heart Pacemaker <input type="radio"/> | Parathyroid Disease <input type="radio"/> | Ulcers <input type="radio"/> |
| Convulsions <input type="radio"/> | Heart Trouble/Disease <input type="radio"/> | Psychiatric Care <input type="radio"/> | Venereal Disease <input type="radio"/> |
| | | | Yellow Jaundice <input type="radio"/> |

Have you ever had any serious illness not listed above? Yes No _____

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 _____



HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness

Printed Name of Patient or Legal Representative Witness

Date:



FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance to your appointment.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash and most major credit cards. Outside financing is available through CareCredit upon request and approval.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be, it is not a guarantee. If you need exact payment of benefits, then a pretreatment is required, which could take up to 6 weeks. A predetermination still does not guarantee payment.

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your plan does not pay within a reasonable time, you must pay any outstanding balance and seek reimbursement from your dental plan. Also remember, dental insurance plans are not designed to cover all of your dental needs.

I have chosen to allow Encore Dentistry to file my insurance and accept full responsibility for this account and for all dentistry performed upon myself in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits.

Print Name of Patient or Responsible Party

Signature

Date