RUSSELL BRANCH
DENTAL & ORTHODONTICS

We are pleased to welcome you and/or your child to our practice.
We look forward to working with you in maintaining your oral health!

PATIENT INFORMATION:

Name:_____Birthdate: _____ SSN:_____

Address: _____City: _____State: _____ Zip Code: _____

Phone Nb (cell): _____ Phone nb (work):_____ E-mail:_____

Whom may we thank for referring you?: Direct Mail Google Family/Friends Insurance Other: _____

RESPONSIBLE PARTY- If same as above please skip to Emergency contact.

Name:_____ Birthdate: _____ Relationship to Patient: _____

Address: _____City_____State_____Zip code:_____

Phone Nb (cell):_____phone nb (work):_____E-mail:_____

EMERGENCY CONTACT:

Name: _____ Phone Number: _____Relationship to Patient:_____

DENTAL FINDINGS AND HISTORY:

Reason for today's Visit: _____ Date of Last Dental Visit: _____

Have you ever had any complications following dental treatment: YES NO

If yes, please describe: _____

MEDICAL HISTORY:

Physician's Name: _____Date of Last Visit: _____Phone #: _____

Pharmacy: _____City:_____ Phone #: _____

Have you ever been hospitalized : YES NO
If yes, please describe: _____

Please circle if you have any of the following:

High Blood Pressure	Low blood pressure	History of stroke	Other heart pb:_____
Fainting/dizziness	Shortness of breath	Asthma	Other breathing problem_____
Diabetes	Stomach ulcer	Kidney disease	Epilepsy
Liver disease	Hepatitis	HIV/AIDS	Glaucoma
Thyroid problem	Jaw pain	Anxiety	Depression
Cancer	Chemotherapy	Radiation therapy	

Other condition(s):_____

Have you ever taken any of these medications?

Blood Thinners YES NO / Coumadin Warfarin Other blood thinner:_____

Diet Medications: YES NO / Dexfenfluramine Fen-Phen Pondimin Redux

Have you ever used Bisphosphonate medication? YES NO

Are you allergic to:

Aspirin
Barbiturates
Codeine
Ibuprofen
Latex
Local Anesthesia
Metals(i.e. nickel)
Penicillin
Other: _____

Please list All Medications taking now :1-_____2-_____

3-_____/ 4-_____/5-_____

_____

Women:

Are you pregnant: _____ Due Date: _____ Are you nursing: _____Taking birth control pills: _____

Patient Signature :_____ Date:_____

Doctor signature:_____date_____

HIPAA Compliance Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health Information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations
The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of information, but the practice does not have to agree to those Restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then Cease.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your dental conditions with any member of your family?	**YES**	**NO**

If YES, please name the family members allowed:
_____
_____
_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

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Financial Policy

Payment for services, including deductibles and copayments, are due at the time of service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing i.e (CareCredit) must be made before starting treatment.

Russell Branch Dental & Orthodontics accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

Cancellation & Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, **we request at least 48 hours advanced notice if you will not be able to make your appointment. Missed appointment or late cancellation may result in a fee of $50.00 per missed appointment.**

Please indicate your understanding and acceptance of these financial policies by signing below.

Patient's name _____ Date_____

Patient's, Parent/Guardian signature_____ Date_____

Thank you for choosing Russell Branch Dental & Orthodontics. Our primary mission is to provide the best & most comprehensive dental care available. If you have any questions regarding our policies or your treatment, please do not hesitate to ask.