PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____
FIRST MI LAST

ADDRESS_____ CITY_____ STATE_____ ZIP_____

E-MAIL_____ SS#_____ BIRTHDATE_____ PHONE #_____

MOBILE PHONE #_____ CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED

IF COLLEGE STUDENT, F.T./P.T., NAME OF SCHOOL_____

PATIENT'S/PARENT'S EMPLOYER_____ WORK PHONE #_____

BUSINESS ADDRESS_____ CITY_____ STATE_____ ZIP_____

SPOUSE OR PARENT'S NAME_____ EMPLOYER_____ WORK PHONE #_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE #_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE #_____ DRIVER'S LICENSE #_____ D.O.B._____ SS#_____

EMPLOYER_____ WORK PHONE #_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

A Finance charge will be assessed on any outstanding balance using a periodic rate of 1.5% - annual percentage rate of 18% - The outstanding balance is that part of the balance remaining unpaid after payments and credit adjustments have been subtracted. Accounts sent to collections are liable for all costs. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ (X)_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____

PATIENT MEDICAL HISTORY

PATIENT'S NAME_____**DATE OF BIRTH**_____

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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Y	N
1. ARE YOU IN GOOD HEALTH……..	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR……	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME:_____ ADDRESS_____ PHONE # _____		
5. CURRENTLY UNDER THE CARE OF A PHYSICIAN……	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN: _____		
7. ARE YOU TAKING ANY MEDICATION(S), INCLUDING NON-PRESCRIPTION MEDICATION IF YES, PLEASE LIST _____		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING……	☐	☐
9. DO YOU BRUISE EASILY……	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION……	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS…	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX……	☐	☐
13. DO YOU USE TOBACCO……	☐	☐
14. DO YOU OR HAVE YOU USED		
15. CONTROLLED SUBSTANCES……..	☐	☐
16. ARE YOU WEARING CONTACT LENSES…….	☐	☐
17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT…….	☐	☐

WOMEN ONLY:

	Y	N
ARE OR DO YOU THINK YOUR PREGNANT……..	☐	☐
TAKING BIRTH CONTROL PILLS……..	☐	☐
ARE YOU NURSING…….	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	Y	N		Y	N
LOCAL ANESTHETICS LIKE NOVOCAINE ……	☐	☐	PENICILLIN OR OTHER ANTIBIOTICS…….	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS ……..	☐	☐	ASPIRIN ……..……..	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.) …….	☐	☐	IODINE……	☐	☐
LATEX/RUBBER……	☐	☐	SULFA DRUGS……..	☐	☐
OTHER (PLEASE LIST) _____					

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	Y	N		Y	N
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER……	☐	☐	PERSISTENT COUGH……	☐	☐
SCARLET FEVER……	☐	☐	COUGH THAT PRODUCES BLOOD……	☐	☐
HEART DEFECT OR HEART MURMUR……..	☐	☐	CHEMOTHERAPY (CANCER, LEUKEMIA)……..	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA……..	☐	☐	SEXUALLY TRANSMITTED DISEASE……..	☐	☐
CHEST PAIN……	☐	☐	EPILEPSY OR SEIZURES……	☐	☐
SHORTNESS OF BREATH……..	☐	☐	ANEMIA……	☐	☐
PACEMAKER……	☐	☐	GLAUCOMA……..	☐	☐
HEART SURGERY……..	☐	☐	NERVOUSNESS……	☐	☐
HIGH/LOW BLOOD PRESSURE……..	☐	☐	TONSILLITIS……	☐	☐
CONGENITAL HEART PROBLEM……	☐	☐	TUMORS……	☐	☐
SWELLING OF FEET, ANKLES, HANDS……	☐	☐	MENTAL HEALTH CARE……	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE……	☐	☐	BACK PROBLEMS……	☐	☐
STROKE……	☐	☐	CHEMICAL DEPENDENCY……	☐	☐
SINUS TROUBLE……	☐	☐	MITRAL VALVE PROLAPSE……	☐	☐
LUNG OR BREATHING PROBLEMS……	☐	☐	CORTISONE TREATMENT……	☐	☐
ASTHMA OR HAY FEVER……	☐	☐	COLD SORES/FEVER BLISTERS……	☐	☐
HIVES OR SKIN RASH……	☐	☐	HYPOGLYCEMIA……	☐	☐
FAINTING OR DIZZY SPELLS……	☐	☐	EATING DISORDERS……	☐	☐
DIABETES……	☐	☐	TUBERCULOSIS……	☐	☐
AIDS OR HIV INFECTION……	☐	☐	KIDNEY TROUBLE ……	☐	☐
THYROID PROBLEMS……	☐	☐			
ALLERGIES……..	☐	☐			
ARTHRITIS OR RHEUMATISM……	☐	☐			
JOINT REPLACEMENT OR IMPLANT……	☐	☐			

Joe A. Harkins, DDS
Jeff K. Hancock, DDS
11010 Quaker Ave.
Lubbock, TX 79424
806-795-4272

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name:_____
Address:_____
Telephone:_____E-Mail:_____
Social Security #_____

Section B: 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 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 of other important matters about your protected health information. A copy of our Notice 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. Those changes may apply to any of your protected health information that we maintain.

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

Contact Person:Dr. Jeff Hancock_____
Telephone: 806-795-4272_____Fax: 806-791-2273_____

E-Mail:_____
Address11010 Quaker Ave.
Lubbock, TX 79424_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person 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 to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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's Name:_____
Relationship to Patient:_____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____