ASCENT DENTAL

Date: ______________

Welcome To Our Office

Thank you for choosing our office.
In order to serve you properly we will need the following information (please print) all information is strictly confidential.

PatientsName:____
Last First MI

Social Security:________________Sex: (F)(M) Date of Birth:______________________

Responsible Party Information

Name: ____Marital Status: ________
Last First MI

Address: ________________________City______________State__________Zip Code______

Home Phone Number________________ Cell______________ Work Number ____________

Relationship to Patient________________ Date of Birth____________ Employer____________

Reason for today's visit? ____

Who can we thank for referring you to our office? ________________ Email________________

Emergency Phone Number ____

Medical History

Are you seeing a physician? YES NO

Name and address of physician(s)____

What medications is patient currently taking? ______________________________________

Female, are you pregnant? YES or NO If yes so how long? ______________________________

Circle any of the following which you had or have at present:

- Heart Disease
- High Blood Pressure
- Blood Disease
- Rheumatic Fever
- Heart Murmur
- High Cholesterol
- Heart Pacemaker
- Diabetes
- Scarlet Fever
- Anemia
- Kidney Problems
- Epilepsy or Seizure
- Ulcers
- Tuberculosis
- Asthma
- Hay Fever
- Nervousness
- Thyroid Disease
- Arthritis
- Sickle Cell Disease
- Glaucoma
- Pain in jaw
- HIV
- Hepatitis

OTHER____

Circle any of the following medications you are allergic to:

- Local Anesthetic
- Codeine
- Aspirin
- Sulfa Drugs
- Penicillin
- Other ____________________

To the best of my knowledge, all of the following answers are correct. I will notify office if there are any changes to my health or changes in medication consumption at next appointment.

X______________________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT AND REVIEW IT CAREFULLY.

Summary:

By law we are required to provide you with our Notice of Privacy Practices (NNP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect a copy of your information;
2. The right to request corrections on your information;
3. The right to request your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical protected health information is secure with us. This Notice of Privacy Practices contains information how we ensure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this Notice of Privacy Practices. I further understand that the practice will offer me updates to this notice. Should it be modified or changed in any way I will receive a copy.

____
Printed Name of Patient

____
Signature of Patient/Parent/Legal Guardian