Privacy and Communication Consent

Patient Name: ______________________________ Date of Birth: ______________________

Initial Below

I ______ Do Agree   I ______ Do not Agree

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am aware the message sent my consists of appointment reminders, recall visits, information request, and patient satisfaction or reviews. I further agree that I am responsible for providing the dental practice any updates to my email address and / or mobile phone number. My most preferred method of electronic communication:

Initial Below

______ Text messaging

______ Email Address I would like to receive correspondence at:______________________________

I can withdraw my consent to electronic communication at any time by calling:
xrays@Whitesandsfamilydental.com Or 575-434-1186. Thank you
Patient Signature: ______________________________________ **Date:** ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.
****You may refuse to sign this acknowledgment****
I ____ have received a copy of this office's Notice of Privacy Practices.
Sign: ________________________________ **Date:** ______________________________________
Authorization to Release information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act of people other than yourself.

I, ________________________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____
{Please Print Name and Relationship}

____
{Please Print Name and Relationship}

____
{Please Print Name and Relationship}

Office Use: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: 1. Individual refused to sign 2. Communication barriers prohibited obtaining information 3. an emergency prevented acknowledgment 4. Other______________

White Sands Family Dental

Patient name: ______________________________ Preferred name: ____________________ DOB____________
Mailing Address: __________________________________ City: ______________ State: ______ Zip: ____________
SSN: ________________ Gender: Female Male Marital status: Married Single Domestic Partner Minor child
Cell phone: ________________ Home phone: ______________ Email address: ____________________________
Whom may we thank for referring you to our Practice? ____

Primary Insurance

Primary Insured: ______________________________ DOB: ____________________ SSN: ____________________
Address: ______________________________________ City: ______________ State: ______ Zip: ________
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: ____________________ Dental Insurance Company: ________________ ID #: ____________________

Federal Employees

Federal Employee Medical Insurance: BCBS ID: R______________ Basic/PPO GEHA ID: ________________

Secondary Insurance

Name: __________________________________ DOB: ____________________ SSN: ____________________
Address: ______________________________________ City: ______________ State: ______ Zip: ________
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: ______________________ Insurance Company: ____________________ ID #: __________________

Responsible Party (This must be filled out please)

Name: __________________________________ Relationship to patient: ____________________________
Address: ______________________________________ City: ______________ State: ______ Zip: ________
DOB: __________________ SSN: ____________________ Daytime Phone: ______________________
Employer: ____ Work phone: ______________________

Insurance Policy

Your insurance contract is an agreement between your insurance company and yourself. We are not a party to that contract. Your complete insurance information must be presented at the time services are provided. All insurance co-pays and deductibles must be paid at the time of service. Insurance claims are electronically filled to expedite carrier payments, however, the patient is responsible for any unpaid charges due to exclusions and limitations written in per your plan provisions. I hereby authorize White Sands Family Dental to furnish information to my dental carrier concerning my treatment and I hereby assign to the doctors all payments for dental treatment rendered to myself or my dependents.

No-Show/ Late Cancellation/Late Charges

- There is a charge of $25.00 for not showing up for your scheduled appointments. This charge can be waived when you call to reschedule your appointment and notify us of the reason for the no show to the previous appointment. If your account shows repeated missed appointments or cancellations without 48 hours' notice, you may be asked to secure your next appointment with a deposit which will be forfeited if you do not show for the appointment that required a deposit
- I am aware that failure to keep this account current may result in the doctor being unable to provide additional dental services. In the case of default on payment of this account for any reason, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signed: ____ Date: ______________________________

Patient Medical History

Do you have or have you had any of the following? Please circle Y for yes or N for no on all three columns

Y N Heart Disease
Y N Congenital Heart Lesions
Y N Stent
Y N Prolonged Bleeding Disorder
Y N Hay fever
Y N Ulcers
Y N Hepatitis Type ______
Y N Kidney Disease
Y N Cancer/Chemotherapy
Y N HIV/AIDS
Y N Fainting Spells
Y N Pregnant
Y N Artificial Joints: Where__________
Y N Thyroid
Y N Smoke/ chew Tobacco
Y N Substance Abuse: What_________

Y N Heart Murmur/MVP
Y N Rheumatic Fever
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Sinus Trouble
Y N Liver Disease
Y N Diabetes
Y N Radiation Therapy
Y N Immune Suppressed Disorder Type:
Y N STI/Herpes
Y N Glaucoma
Y N Nursing
____
Y N TB or Lung Disease
_________ per day Years:___________
_______ How often:______________

Y N Stroke
Y N Pacemaker
Y N Anemia
Y N Asthma
Y N Epilepsy/Seizure
Y N Jaundice
Y N Arthritis
Y N Tumor/Malignancy
____
Y N Hearing loss
Y N Depression
Y N Taking Birth Control
Y N Implants (cosmetic)(medical) (dental)
Y N E-cigarettes/ Vape
Have you quit? **Y N** When:___________
Have you quit? **Y N** When:___________

Y N Do you take Fosamax, Boniva, Actonel, Aredia, Zometa, etc. For Osteoporosis or any other condition?
Y N Had major Surgery? Year: _____________ Type:______________ Year:___________ Type:___________

Are You Allergic to any of the following? (Please Circle)

Aspirin Ibuprofen Sulfa Drugs Penicillin Codeine Latex Local Anesthetics
Other allergies to medications: ____

Please List the medications you are currently taking with dosage and for what condition (Including over the counter medication & Aspirin)

RX:_____________________________ Condition___________________________ How often?_________________
RX:_____________________________ Condition___________________________ How often?_________________
RX:_____________________________ Condition___________________________ How often?_________________
RX:_____________________________ Condition___________________________ How often?_________________

Primary Medical Care Doctor: ________________________________ Phone: ________________________________

Patient Dental History

What is the reason for your appointment today? ____
Previous Dentist__________________________ Last Visit______________________ Last Cleaning________________
Are you nervous about seeing the dentist? Y N Please Explain ____________________________________
How often do you brush? ____________________________ Floss?____________________________________
(Please Circle)

Y N I clench or grind my teeth during the day or while sleeping
Y N I My gums Bleed while brushing or flossing
Y N I have had orthodontics
Y N I have had oral surgery

Y N My gums feel tender or sore
Y N I have eating problems
Y N I have had gum Surgery
Y N I prefer tooth colored fillings

Y N Would you like to change anything about your smile? Explain? ______________________________
What are you dental priorities?____

Consent

I Understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the Providers at White Sands Family Dental to perform any necessary dental services, with my informed consent, that may be needed during diagnosis and treatment.

Signed:_________________________________ Date:_________________________________