

**DENTOLOGY SOLUTIONS**  
**HIPAA PATIENT CONSENT FORM**

Page 1/1

☐ scanned

I understand that I have certain rights and privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Oakfield Dental

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and the disclosures of my protected health information and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy with this restriction.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I authorize the release of or discussion of protected health information including the diagnosis, records, treatment recommended or rendered, and claims information to:

☐ Information is **not** to be released to anyone

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print patient & guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

# DENTOLOGY SOLUTIONS

## COMMUNICATION POLICY & INFORMED CONSENT GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternate treatment, or options of no treatment.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post-op treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. I understand that it is my responsibility to immediately notify the office of any changes to my address, phone number, email address.
2. I authorize confirmation of my dental appointments, recall appointments, and outstanding treatment reminders by phone, text, or email unless I inform the office of non-participation. By signing this form and signing up for texts, you consent to receive SMS text messages from Dentology Solutions at the number provided, including messages sent by autodialer. Consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. Unsubscribe at any time by replying STOP to the messages. See our website [www.dentologysolutions.com](http://www.dentologysolutions.com) for the Privacy Policy & Terms.
3. I understand that Dentology Solutions strives to provide the highest quality service to our patients. Therefore, telephone calls may be recorded or monitored for quality assurance. My signature on this form acknowledges consent and agreement to Dentology Solutions recording and monitoring of telephone calls. Taped recordings of telephone conversations may be made with or without an immediate notification that it is occurring at that time. This consent shall remain in effect until revocation of my consent in writing.
4. I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
5. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. The most common occurrence being cavities that are larger than what was seen clinically or on the x-ray, which may require further treatment such as including additional surfaces of a tooth found to be infected, placing an indirect pulp cap for cavities approximating the pulp of a tooth, or resulting in root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes as necessary.

Print patient & guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

**DENTOLOGY SOLUTIONS**  
**PATIENT FINANCIAL AGREEMENT**

1. I understand that full payment is due at the time of service for myself or any of my dependents. If I do not have my payment, I understand that my appointment may be rescheduled.
2. I understand that a returned check will result in a \$25 service charge and all future payments being required in the form of cash or credit card.
3. I will only be sent a statement if my balance exceeds \$5 and I will only receive a refund if the credit amount is over \$10. Refunds will be issued within 4-6 weeks from the date requested.
4. I understand that if I discontinue treatment for any requested procedure, including, but not limited to partial or complete dentures, crowns, bridgework, and surgical preparatory work, I remain responsible for paying all lab-related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled to, for discontinuing treatment.
5. I understand that I must inform Dentology Solutions in writing of any concerns, questions, or disputes I may have concerning my treatment and charges in a timely manner.
6. I understand that balances over 30 days may be charged a 1.5% monthly compound interest.
7. I understand that if my account is turned over to a collection agency, I will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of my outstanding balance, court costs and attorney fees.
8. I understand that Dentology Solutions currently charges \$30.00 for a broken or cancelled appointment without a 24 hour notice. If a broken or cancelled appointment occurs more than two times, I may not be allowed to schedule again.

I have read and understand the above Financial & Communication Policy and agree to meet all financial obligations.

Print patient & guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

# DENTOLOGY SOLUTIONS MEDICAL HISTORY FORM

Page 1/2

☐ scanned

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Emergency contact & phone: \_\_\_\_\_

Primary care doctor name & phone: \_\_\_\_\_ Last physical exam: \_\_\_\_\_

Pharmacy name, phone /address: \_\_\_\_\_

Y/N | Do you smoke / smokeless tobacco / E-cigarettes? Frequency: \_\_\_\_\_

Y/N | Have you used controlled substances in the past 48 hours? Explain: \_\_\_\_\_

*Taking any illicit drugs can impair judgement, so you would not be allowed to sign a consent form*

*Taking cocaine and receiving anesthetic with epinephrine can be fatal*

Y/N | Taken Phen-Fen, Redux, or bisphosphonate medications in the past 15 years?

(i.e. Fosamax/Binosto (Alendronate), Actonel/Altevia (Risedronate), Reclast/Zometa/Aclasta (Zoledronic acid), Boniva (Ibandronate), Didronel (Etidronate), Aredia (Pamidronate), Skelid (Tiludronic acid))

Check one: ☐ Pill form ☐ Injection Start & end dates: \_\_\_\_\_

Y/N | Recent surgeries within the past 5 years? Date: \_\_\_\_\_ Explain: \_\_\_\_\_

Y/N | History of head and neck injury? Explain: \_\_\_\_\_

Y/N | Are you pregnant / trying / nursing? Due date: \_\_\_\_\_

Y/N | Taking oral contraceptives? *Taking antibiotics can prevent oral contraceptives from working*

## Allergies or adverse reactions:

- |                                       |                                      |                                                  |                                      |
|---------------------------------------|--------------------------------------|--------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> None         | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Local Anesthetic        | <input type="checkbox"/> Pine Nuts   |
| <input type="checkbox"/> Acrylic      | <input type="checkbox"/> Dyes        | <input type="checkbox"/> Metals                  | <input type="checkbox"/> Steroids    |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Latex       | <input type="checkbox"/> Penicillin/ Amoxicillin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Other: _____ |                                      |                                                  |                                      |

Any heart surgeries or conditions:

Y/N | Psychiatric Condition

Y/N | Cancer

Y/N | Alzheimer

Y/N | Chemotherapy

Y/N | Dementia

Y/N | Radiation

Any lung surgeries or conditions:

Y/N | Epilepsy/ Seizures

Y/N | Immunocompromised

Y/N | Fainting Spells/ Dizziness

Y/N | Cold Sores/ Fever Blisters

Y/N | Stroke

Y/N | Herpes

Any bleeding disorders:

Y/N | CPAP for Sleep Apnea

Y/N | AIDS/ HIV+

Y/N | High Blood Pressure

Y/N | Tuberculosis

Y/N | Sinus Issues

Y/N | Shingles

Any artificial valves or joints?

Y/N | Osteoporosis

Y/N | Hepatitis A, B, C

Y/N | Acid Reflux/ GERD

Y/N | Liver Disease

Y/N | Diabetes Type I / II

Y/N | Kidney Disease/ Dialysis

Do you require antibiotics prior to dental procedures?

Y/N | High Cholesterol

Y/N | Cortisone Medication Use

Any other medical conditions, serious illnesses, hospitalizations, or accidents?

# DENTOLOGY SOLUTIONS MEDICAL HISTORY FORM

Last cleaning? Why did you switch dentists? \_\_\_\_\_

Any known uncompleted dental treatment or problems? \_\_\_\_\_

Anything we should know to improve your experience? \_\_\_\_\_

Have you experienced any of the following?

Y/N | Jaw joint (TMJ) pain

Y/N | Sensitive teeth

Y/N | I can't lean back fully in dental chair

Y/N | Grind/clench

Y/N | Dry mouth

Y/N | Happy with shade of teeth

Y/N | Wear a night/bite guard

Y/N | Past deep cleaning

Y/N | Happy with arrangement of teeth

## Are you taking any medications?

☐ No medications ☐ List scanned in ☐ Please list below:

| MEDICATION NAME | PURPOSE |
|-----------------|---------|
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |
|                 |         |

I attest to the accuracy of the information and understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered.

Print patient/guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_