208 West 19th Avenue
Gulf Shores, AL 36542
Office: 251-968-8789

info@Serenity-Dental.com
www.Serenity-Dental.com

Patient Information

Date: _____
Last Name: _____ First Name: _____ M.I. _____
Address: _____
City: _____ State: _____ Zip: _____

Birthdate: (DD/MM/YR) ___/___/___ Age: _____ M F
SSN: ____-____-____ (please circle one) Married Single Minor Other

Contact Information

Email: _____
Phone Numbers:
Home: (____)_____ Work: (____)_____ Cell: (____)_____
Best Time and Phone Number to Reach You: _____

EMERGENCY CONTACT:
Name: _____ **Relationship:** _____
Home: (____)_____ Work: (____)_____ Cell: (____)_____

Dental Insurance

Primary Insurance
Subscriber's Name: _____
Relationship to Patient: _____
Birthdate: _____ SSN: _____
Insurance Group: _____
Group #: _____ ID#: _____
Phone: (____)_____

Secondary Insurance
Subscriber's Name: _____
Relationship to Patient: _____
Birthdate: _____ SSN: _____
Insurance Group: _____
Group #: _____ ID#: _____
Phone: (____)_____

Dental History

Reason for Today's Visit: _____
Former Dentist: _____ Date of Last Visit: _____
City / State: _____ Date of Last X-Rays: _____
How Often Do You Brush? _____ How Often Do You Floss? _____

Please circle Yes or No to all that apply.

Bad Breath	Y	N	Jaw pain/tenderness	Y	N
Bleeding Gums	Y	N	Lip/Cheek biting	Y	N
Blisters on lips or mouth	Y	N	Loose teeth/broken filling	Y	N
Burning sensation on tongue	Y	N	Orthodontic treatment	Y	N
Chew on one side of mouth	Y	N	Periodontal treatment	Y	N
Cigarette/Pipe/Cigar Smoking	Y	N	Sores/growths in mouth	Y	N
Clicking/Popping jaw	Y	N	Sensitivity to sweets	Y	N
Dry Mouth	Y	N	Sensitivity to cold	Y	N
Grinding Teeth	Y	N	Sensitivity to hot	Y	N
Food collection between teeth	Y	N	Sensitivity when biting	Y	N

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Medical History

In order to provide you with the best dental care possible it is imperative that we have your known medical history.

Physician's Name: _____ Phone: (____)_____
Date of Last Visit: _____
Preferred Pharmacy: _____ Phone: (____)_____

Please circle Yes or No to all that apply.

AIDS	Y	N	Gallstones	Y	N	Respiratory Disease	Y	N
Anemia	Y	N	Glaucoma	Y	N	Scarlet Fever	Y	N
Arthritis/Rheumatism	Y	N	Headaches	Y	N	Shortness of Breath	Y	N
Asthma	Y	N	Heart problems	Y	N	Sinus Trouble	Y	N
Back Problems	Y	N	Hepatitis Type ____	Y	N	Skin Rash	Y	N
Cancer	Y	N	Herpes	Y	N	Special Diet/Weight Loss	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Chemotherapy	Y	N	HIV positive	Y	N	Swollen Feet/Ankles	Y	N
Circulatory Problems	Y	N	Jaundice	Y	N	Swollen Neck Glands	Y	N
Cortisone Treatments	Y	N	Kidney Disease	Y	N	Thyroid Problems	Y	N
Cough, Persistent/Bloody	Y	N	Liver Disease	Y	N	Tonsillitis	Y	N
Diabetes	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Emphysema	Y	N	Nervous Problems	Y	N	Tumors/Growths	Y	N
Spilepsy	Y	N	Psychiatric Care	Y	N	Ulcers	Y	N
Fainting/Diziness	Y	N	Radiation Treatment	Y	N	Venereal Disease	Y	N

Please circle Yes or No if you have been DIAGNOSED with any of the following.

Artificial Heart Valve	Y	N	Artificial joints	Y	N	Blood disease	Y	N
Congenital heart lesions	Y	N	Heart Murmur	Y	N	Hernia repair	Y	N
Mitral Valve Prolapse	Y	N	Pacemaker	Y	N	Rheumatic fever	Y	N

Medication History

Please circle Yes or No if you have ever been ALLERGIC to any of the following.

Aspirin	Y	N	Codeine	Y	N	Ibuprofen	Y	N	Latex	Y	N
Local Anesthetic	Y	N	Metals	Y	N	Penicillin	Y	N	Other _____		

Have you ever had any complications following dental treatment? Y N
Have you ever been hospitalized? Y N
If yes, please describe: _____
Do you have other health concerns? _____

Women:
Are you pregnant? Y N Are you taking Birth Control? Y N

Please list all current medications you are taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

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Consent For Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, and other diagnosis aids deemed appropriate by the doctor to make the diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment, mutually agreed upon by me, and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedative, and other medications as necessary, I fully understand that using anesthetic agents embodies certain risks. I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. ***I understand that payment is due at time of service unless other arrangements have been made.*** In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) will be added to my account.
5. I understand that I shall be liable for all damages, costs, and expenses, including but not limited to attorney's fees incurred by the doctor, or the office in enforcing terms and conditions of this agreement and/or collecting unpaid balances incurred by me.
6. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay fees less than the actual bill of service.

Patient Signature: _____ Date: _____

Parent/Guardian if Minor: _____ Relationship: _____

Witness: _____

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Insurance Responsibility

Due to the many changes in insurance policies, it is no longer an easy task to interpret and watch individual policy. Although we try and stay aware of changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to all services rendered to be submitted for insurance coverage. Is is your responsibility to know your individual coverage; failing to comply with the suggestion could result in you, the patience, being responsible for all charges incurred. Please remember that your insurance policy is between you and your insurance company, and not with the insurance company and the doctor.

You are ultimately responsible for what insurance does not cover.

Patient Signature: _____ Date: _____

Parent/Guardian if Minor: _____ Relationship: _____

Witness: _____

Patient Privacy and Consent

Due to Doctor-Patient confidentiality laws imposed by HIPPA, this office will be unable to discuss or release any information regarding your treatment unless otherwise instructed by you, the patient.

I, _____, hereby authorize Serenity Dental Studio at their discretion, to discuss or release any necessary documents regarding my treatment to the following individuals only:

_____ _____

_____ _____

Patient Signature: _____ Date: _____

Print Name: _____

Cancellation and No-Show Policy

We are grateful that you have chosen Serenity Dental Studio for your dental needs. We set aside generous time for each patient and schedule daily accordingly, When a patient doesn't make it to a scheduled appointment please know this is the time another patient could've taken to receive the dental care that they need. Therefore, we have implemented the following policy:

*If you need to cancel your appointment, please do so with a minimum of **48-hour notice**. If less than 48 hours you will be charged a **$20.00 cancellation fee**. If you do not show up for a scheduled appointment you will be charged a **$20.00 no-show fee**.*

Patient Signature: _____ Date: _____

Print Name: _____

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HIPAA Notice of Privacy Practices

This notice describes how we, Serenity Dental Studio, may use and disclose your Protected Health Information (PHI) and how you can get access to this information. Please review it carefully, The privacy of your health information is important to us.

We understand that you health information is confidential and we are committed to protecting it. We understand our obligations are as follows:

- We are required by law to maintain the privacy and security of your PHI.
- We will follow the duties and privacy practices described in this notice and provide you with a copy of it when requested.
- We will not use or share your PHI other than described in this notice, unless you tell us we can in writing.

We may use or share your PHI in some of all of the following ways:

- Provide and coordinate any treatment rendered to you or your child among several healthcare providers who may be involved in that treatment directly and indirectly. An example of this is providing your PHI to a specialist doctor.
- Conduct normal healthcare operations such as quality assessment and improvement activities. An example of this is using your PHI to schedule and and confirm appointments and surgery times.
- Confirm coverage, bill, and obtain reimbursement for services from insurance companies or other entities. An example of this is using your PHI to send your insurance company a bill for your visit and/or verify coverage prior to your appointment.
- Contribute to public health and safety issues as required by law.
- Comply with state or federal law enforcement.
- Respond to court or administrative orders or other legal actions.
- Contact you by phone, electronically or in writing, in regards ro your appointments, treatment or other health benefits and services, in addition to other office communications, that may be of interest to you.

We also acknowledge that you have certain rights in regards to your PHI, these are:

- You have the right to request a paper copy of this HIPAA Notice of Privacy Practices from us.
- You have the right to get an electronic or paper copy of your medical records. We request that you sign a "Medical Records Release Form" and submit it to our office.
- You have the right to be notified if your PHI is intentionally or unintentionally disclosed.
- You have the right to ask us to correct your health information that you think is incorrect or incomplete.
- You have the right to request us to contact you in a specific way (for example, home or mobile phone). We will comply to all reasonable requests.
- You have the right to request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment or health care operations, however, we are not required to agree to the requested restrictions, but if we do agree then we are bound to abide by such restrictions.

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HIPAA Notice of Privacy Practices - Acknowledgement

I acknowledge receipt of the HIPAA Notice of Privacy Practices from Serenity Dental Studio.

Patient Signature: _____ Date: _____

Print Name: _____