

IMPORTANT: To fill out this form, open it in a new tab on a computer, or use autofill on mobile. Then save it and email it back to rogosindental@gmail.com, or print it and bring it to your appointment. Type an **X** in the small box next to every item that applies to you.

Today's date (MM/DD/YYYY)

1. Patient Information

Patient Details

Last name

First name

Date of birth (MM/DD/YYYY)

Address

City

State

ZIP code

Sex (optional): ☐ Male ☐ Female ☐ Prefer not to say

Marital status (optional): ☐ Married/Partnered ☐ Single

Contact & Employment

Phone

Email

Occupation

Employer / school

Referred by

Emergency Contact

Emergency contact name

Relationship

Emergency contact phone

2. Dental Insurance & Assignment

Responsible Party / Subscriber

Responsible party

Relationship to patient

Subscriber name

Subscriber DOB (MM/DD/YYYY)

Primary Insurance

Primary insurance company

Primary group number

Primary SSN / Subscriber ID

Additional Insurance

Additional insurance company

Additional group number

Additional SSN / Subscriber ID

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company(ies) listed above and assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Insurance authorization printed name

Insurance authorization date (MM/DD/YYYY)

Insurance Authorization Signature

Sign here: use your PDF app's Fill & Sign / signature tool, or type your full legal name in the box.

3. Dental Information

Reason for today's visit

Former dentist

Former dentist city/state

Date of last dental visit (MM/DD/YYYY)

Date of last dental X-rays (MM/DD/YYYY)

4. Dental History

Have you experienced any of the following? (mark X if yes)

Bad breath	☐	Food collection between the teeth	☐	Sensitivity to cold	☐
Bleeding gums	☐	Grinding teeth	☐	Sensitivity to heat	☐
Blisters on lips or mouth	☐	Gums swollen or tender	☐	Sensitivity to sweets	☐
Chew on one side of mouth	☐	Lip or cheek biting	☐	Sensitivity when biting	☐
Cigarette, pipe, or cigar smoking	☐	Loose teeth or broken fillings	☐	Sores or growths in your mouth	☐
Clicking or popping jaw (TMJ)	☐	Mouth breathing	☐	Orthodontic treatment	☐
Dry mouth	☐	Mouth pain, brushing	☐	Periodontal treatment	☐
Fingernail biting	☐	Pain around ear	☐		

5. Health History

Physician's name

Date of last physician visit (MM/DD/YYYY)

Medical Conditions: have you had any of the following? (mark X if yes)

AIDS/HIV	☐	Fainting or dizziness	☐	Respiratory Disease	☐
Anemia	☐	Glaucoma	☐	Rheumatic Fever	☐
Arthritis, Rheumatism	☐	Headaches	☐	Shortness of Breath	☐
Artificial Joints	☐	Heart Problems	☐	Sinus Trouble	☐
Asthma	☐	Heart Murmur	☐	Skin Rash	☐
Back Problems	☐	Artificial Heart Valves	☐	Special Diet	☐
Bleeding abnormally, with extractions or surgery	☐	Mitral Valve Prolapse	☐	Stroke	☐
Blood Disease	☐	Pacemaker	☐	Swollen Neck Glands	☐
Cancer	☐	Hepatitis Type	☐	Thyroid Problems	☐
Chemical Dependency	☐	Herpes	☐	Tonsillitis	☐
Chemotherapy	☐	High Blood Pressure	☐	Tuberculosis	☐
Radiation Treatment	☐	Low Blood Pressure	☐	Tumor or growth on head or neck	☐
Cortisone Treatments	☐	Jaw Pain	☐	Ulcer	☐
Cough, persistent or bloody	☐	Kidney Disease	☐	Venereal Disease	☐
Diabetes	☐	Liver Disease	☐	Weight Loss, unexplained	☐
Emphysema	☐	Nervous Problems	☐		
Epilepsy	☐	Psychiatric Care	☐		

Pregnancy & Other Health Conditions (mark X if yes)

Are you pregnant?	☐	Are you nursing?	☐	Are you taking birth control pills?	☐
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Other health conditions or details

Allergies

☐ Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Latex ☐ Local anesthetic ☐ Penicillin ☐ Sulfa

Other allergies / reactions

Medications & Pharmacy

List medications and related diagnoses

Pharmacy name

Pharmacy address

Pharmacy phone

6. Notice of Privacy Practices Acknowledgment

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided the changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assignment and improvement activities, reviewing the competence or programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights action of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to our use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your care. We will also use our professional judgment and our experience with common practice to make responsible inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Acknowledgment of Receipt

☐ I acknowledge receipt of the Notice of Privacy Practices.

HIPAA patient name

Relationship (if not the patient)

Date (MM/DD/YYYY)

HIPAA Acknowledgment Signature

Sign here: use your PDF app's Fill & Sign / signature tool, or type your full legal name in the box.