Patient Information

Patient Name: ______________________________________ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________

Social Security #: ______________________ Birth Date:______________________

Phone (Home): ___________ (Mobile): _____________ (Work): ___________ Ext:______

Email: ____

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: _____________ Reason for this visit:_______________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Clotting Issues
- ☐ High Cholesterol
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Depression
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ MVP
- ☐ Radiation Treatment
- ☐ Lyme Disease
- ☐ Muscular Sleep Apnea
- ☐ Sleep Apnea
- ☐ Allergy - Amoxicillin
- ☐ Allergy – Z-pak
- ☐ Allergy – Erythro
- ☐ Allergy - Darvon
- ☐ Allergy – Seasonal
- ☐ Allergy – Hay Fever
- ☐ Allergy - Sulfa
- ☐ Allergy - Morphine
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Tylenol
- ☐ Pre-Med – Amox
- ☐ Pre-Med - Other

· Would you like to change anything about your smile? ______________________________

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

• Have you ever had Botox treatments or filler treatments ☐ Yes ☐ No
If so, where have you been treated? ____________________________________

· Are you interested in Botox and filler treatments or learning more about the benefits? ☐ Yes ☐ No
If so, are there any areas of concern that you would like to discuss? ____________________

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:____

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:____

· Are you subject to frequent headaches? ☐ Yes ☐ No

· List all medications, drugs, pills or herbal remedies, including regular doses of aspirin.

____

· FEMALE: Are you taking birth control pills? ☐ Yes ☐ No

· Are you taking dietary supplements? ☐ Yes ☐ No

· Do you smoke or have you previously smoked? ☐ Yes ☐ No

· FEMALE: Are you pregnant? ☐ Yes ☐ No

· Name of Physician: ____ Phone:________________

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have been listed. I am aware that I must notify the practice of any future changes.

____ Date:________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_______________

Name of person or office referring you to our practice:_______________________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________

Insurance Information

Primary

Name of Insured: ____
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #:__________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Insurance Plan Name and Address: ____

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Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #:__________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Insurance Plan Name and Address: ____

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OF PITTSBURGH
DENTAL &
AESTHETICS

I hereby consent to my photograph being taken and the recording of my voice, and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings for advertising, publicity, commercial, or other business purposes. I understand that the term "photograph" as used herein encompasses still photographs, video and motion picture footage.

I hereby release Blink, and any of its associated or affiliated companies, their directors, officers, agents, employees, and appointed advertising agencies from all claims of every kind with respect to such use of my photograph, likeness or voice recording.

If Model is under 18: I, ________________________________, am the parent/legal guardian of the individual named below, and have read this release and approve of its terms.

- Accept
- Deny

Print Name: ______________________________________

Signature: ____

Date: ____________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize my insurance company to pay the dentist all insurance benefits rendered, the use of this electronic signature on all insurance submissions, and the dentist to release all information necessary to secure the payment of benefits.

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.
I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although the revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentially.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ___________ Relationship to Patient: _______________
Signature of patient, parent or guardian

____ Date: ___________ Relationship to Patient: _______________
Signature of guarantor of payment/responsible party