Patient Update Information

Date_____

Name: _____ Preferred Name: _____

Address: _____City: _____State: ____Zip_____

Home Phone (_____) - _____-_____ Work Phone (_____) - _____-_____
Cell Phone (_____) - _____-_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person to contact in case of emergency: _____ Phone (_____) - _____-_____

Please circle one of the following for confirmation e-mail, text, or phone call.
Email Address_____

Has your dental insurance changed? If so, please provide your new information and card:
_____

Medical Update:
Physician: _____

1. Are you under medical treatment now?.....Yes_____ No___

2. Have you been hospitalized for any surgical operations or serious illness since your last visit?.....Yes____ No____

3. Are you taking any medications, including non-prescriptions medication?.....Yes____ No____
If Yes please list them here:

_____
_____
_____
_____
_____

4. Are you allergic to anything .....Yes____ No____
If yes, please list here:

_____
_____
_____

5. Do you have or have you had any of the following?

Cancer..... Yes____ No____
Diabetes.....Yes____ No____
HIV infection or AIDS ..... Yes____ No____
Heart Attack..... Yes___ No____
Heart valve.....Yes____ No____
Hepatitis..... Yes____ No____
High Blood Pressure..... Yes____ No____
Joint replacement or implant .....Yes____ No____
Pacemaker/Defibrillator..... Yes____ No____
Seizures.....Yes____ No____
Sexually transmitted disease.....Yes____ No____
Stroke.....Yes____ No____
Tuberculosis.....Yes____ No____
Other:_____

6. WOMEN ONLY

Are you pregnant or think you may be pregnant?
Yes____ No____

Signature X_____
Relationship to Patient _____

Maple Leaf
IMPLANT & GENERAL
DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

- I have received a copy of this office's Notice of Privacy Practices.
- I understand that my health information can be used for the purposes of treatment, payment, healthcare operations, disaster relief, public health activities, national security, worker's compensation, coroners, law enforcement, in response to a subpoena, and other uses as required by law.
- I understand that I have the right to access and amend my health information. I must put any request in writing. Requests will be granted based on this office's HIPAA policies.
- I understand that this office will contact me by text, phone, email, and mail. I have the right to request, in writing, that this office contact me by specific means and at alternative locations as long as I provide accurate billing information. I understand that if this office is unable to contact me using the ways or locations I have requested, they may contact me using any information they have.
- I understand that this office may disclose my health information to any individual identified by me, in writing, when they are involved in my care or the payment for my care.
- I understand that I can submit, in writing, a request to restrict the normal use of my health information. This office is not required to agree to my request to restrict the use of my health information to obtain payment, unless the service or item I question has been paid for in full.
- I understand that I can submit to this office, in writing, any questions, concerns, or complaints regarding the use of my health information.

Patient Name: _____

Signature: _____
(Must be signed by guardian if patient is under 18)

Print Name of Signature: _____

Date: _____

Maple Leaf
IMPLANT & GENERAL
DENTISTRY

Patient Representative Authorization Form

Patient Name: _____

Patient's Date of Birth: _____

Please list below anyone whom you authorize to have access to your records. Indicate if each patient representative may have access to health or financial records. We will release records to anyone that you list as your representative unless you revoke this authorization in writing. A minor may not be listed as a patient representative.

Both parents must be patient representatives for a minor unless court documentation is presented restricting access of parent(s).

1. Name:_____

   Relationship to patient: _____

   _____health information _____financial information

2. Name:_____

   Relationship to patient: _____

   _____health information _____financial information

3. Name:_____

   Relationship to patient: _____

   _____health information _____financial information

_____ _____

Signature of patient or guardian Date