Kalons & Glidewell DDS, PA

GENERAL CONSENT FORM

SECTION A: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Kalons & Glidewell, DDS, PA may deem necessary for my treatment. I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office and that x-rays are required on a yearly basis for accurate diagnoses.

I understand that Kalons & Glidewell, DDS, PA and their staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed advisable to the dentists at Kalons & Glidewell, DDS, PA. I understand that the use of local anesthetic could result in a hematoma (blood-filled swelling), temporary drooping of the eyelid or mouth, an allergic reaction, or numbness that lasts for several weeks or months (and extremely rare instances, indefinitely).

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Kalons & Glidewell, DDS, PA or their staff will always advise me of any changes. I understand that dental work will ultimately fail if proper oral hygiene is not maintained, and regular checkups are required. If I have clear retainers made for orthodontic retention, I understand that I must wear them nightly to prevent the shifting of teeth.

In the event that Drs. Kalons, Glidewell, or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

SECTION C: SIGNATURES

Patient Signature: _____ Date: _____

If the patient is a minor or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Signature of Parent, Guardian, or Personal Representative: _____

Printed name: _____ Relationship to patient: _____

Kalons & Glidewell, DDS, PA

Patient Information

Patient Name: _____ _____ _____
Last, First MI

Preferred Name: _____ Birthdate: _____ Gender: □ Male □ Female

Social Security #: _____-_____-_____ Parent/Guardian (if patient is a minor): _____

Address: _____
Street City State Zip code

Phone (Home): (_____) _____ (Work): (_____) _____ (Mobile): (_____) _____

Email*: _____*for communication purposes only

Dental and Medical History

Date of Last Dental Visit:(New Patient Only) _____ Reason for this visit: _____

Medical Doctor's Name: _____Medical Doctor's Telephone: (_____)_____

Please list all **medications** (including over-the-counter and herbal) you are currently taking:

_____

Please list any **allergies** you have: _____

Women only, are you: Taking Birth Control Pills? _____ Pregnant? _____ (If yes, what week?_____) Nursing?_____

Emergency Contact:

Name: _____ Phone Number: (_____)_____ Relationship: _____

Do you have or have you ever had any of the following? Please check all that apply.

- □ Abnormal Bleeding
- □ Alcohol Abuse
- □ Allergies
- □ Anemia
- □ Angina Pectoris
- □ Arthritis
- □ Artificial Bones/Joints
- □ Artificial Heart Valve
- □ Asthma
- □ Blood Transfusion
- □ Cancer/Chemotherapy
- □ Colitis
- □ Congenital Heart Defect
- □ Cosmetic Surgery
- □ Diabetes
- □ Difficulty Breathing
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy
- □ Fainting Spells
- □ Fever Blister
- □ Frequent Headaches
- □ Glaucoma
- □ Hay Fever
- □ Heart Attack
- □ Heart Murmur
- □ Heart Surgery
- □ Hemophilia
- □ Hepatitis (A, B, or C)
- □ High Blood Pressure
- □ HIV/AIDS
- □ Kidney Problems
- □ Liver Disease
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Pace Maker
- □ Pneumocystis
- □ Psychiatric Problems
- □ Radiation Treatment
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Seizures
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Tumors
- □ Ulcers
- □ Venereal Disease
- □ Yellow Jaundice
- □ Other:_____

- Do you smoke or use tobacco products? □ Yes □ No
- Have you ever had complications following dental treatment? □ Yes □ No
  If yes, please explain: _____
- Have you been admitted to the hospital or needed emergency care in the past two years? □ Yes □ No
  If yes, please explain:
  _____
- Do you have any other health problems that need further clarification? □ Yes □ No
  If yes, please explain: _____
- **To the best of my knowledge, all of the answers and information provided above are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.**

_____ _____
Signature of patient, parent or guardian **Date**

New Patient Referral Source

- Whom may we thank for referring you to our practice? □ Another patient □ Sign in the building □ Internet
  □ Dental Office □ Yellow Pages □ Work □ Insurance Company □ Other:_____
- Name of person or office referring you to our practice:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____**Date of Birth:** _____

Kalons & Glidewell, DDS, PA is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
□ My voicemail ( )-_____ □ Text to my mobile phone □ My email listed here: _____ _____	□ Appointment Reminders (on voicemail) □ Appointment Reminders (by text) □ Appointment Reminders, X-rays, Treatment Plans, Financials (by email)
□ My spouse (provide name and phone #) _____	□ Appointment Reminders □ Treatment Plans, Financials
□ My parent (provide name and phone #) _____	□ Appointment Reminders □ Treatment Plans, Financials
□ Other (provide name and phone #) _____	□ Appointment Reminders □ Treatment Plans, Financials

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient.**

NOTICE OF PRIVACY PRACTICES:

I have been offered a copy of and had full opportunity to read and consider the office Notice of Privacy Practices. This notice provides a description of treatment, payment activities, healthcare operations, the uses and disclosures of your protected health information, and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to the use and disclosure of my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities, and health care operations.

_____ _____

Signature of Patient or Personal Representative **Date**

Kalons & Glidewell DDS PA

FINANCIAL RESPONSIBILITY

Patient Name: _____

I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance company does not pay its **estimated** portion, I agree that I will be responsible for the account balance. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

I understand that any appointment broken within 24 hours is subject to a missed appointment fee of $50 for hygiene visits and $75 for doctor visits.

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE NAME: _____	INSURANCE NAME: _____
EMPLOYER: _____	EMPLOYER: _____
EMPLOYEE NAME: _____	EMPLOYEE NAME: _____
SSN: _____DOB: _____	SSN: _____DOB: _____
INSURANCE PHONE #: _____	INSURANCE PHONE #: _____

Patient Signature: _____ Date: _____

If the patient is a minor or if this form is signed by a personal representative on behalf of the patient, please complete the following:

Signature of Parent, Guardian, or Personal Representative: _____

Printed name: _____ Relationship to patient: _____