CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

SECTION B: TO THE PATIENT - PLEASE READ CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have received a copy of our Notice of Privacy Practices with this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information.
We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person at this office. Please understand that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent:
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____Date:_____

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

Personal Representative's Name/Relationship to Patient:_____

lf you would like to designate another person (s) to discuss your healthcare, appointments or bills, list and sign below authorizing us to do so:

Name (s):_____

Patient's Signature:_____Date:_____

PATIENT REGISTRATION

Patient's First Name:_____ Last Name:_____ Middle Name:_____
Preferred Name: _____
Patient Is (please check): Policy Holder _____ Responsible Party_____ Dependent _____
Address:_____
City, State, Zip:_____
Cell Phone: _____ Home Phone: _____Work Phone:_____
Birth Date:_____ Age:_____Sex: _____
Marital Status: Married_____ Single _____ Divorced _____ Separated _____ Widowed _____
Social Security: _____
I would like to receive correspondence via (check all that apply): Email____ Text____Messages____Mail ___
Email Address: _____
How did you hear about our office? _____
Responsible Party (if someone other than patient)
First Name: _____ Last Name:_____ Middle Name: _____
Address:_____
City, State, Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone:_____
Birth Date: _____ Social Security: _____
Is another relative of yours a patient at our office?_____
Person to contact in case of an emergency:_____
Closest relative not living with you:_____

Insurance Information

Name of Insured:_____
Relationship of Patient to Insured: Self_____Spouse_____ Child_____Other_____
Insured Social Security:_____Insured's Insurance ID #: _____
Insured Birth Date:_____ Employer: _____
Group #:_____
Insurance Company: _____
Insurance Address:_____
City, State, Zip: _____
Insurance Phone Number: _____

I authorize Dr. Brazdo or designated staff member to take x-rays, study models, photographs, and any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received when due, I understand that a l ½ (l8%APR) may be added to my account.
Patient's Signature: _____ Date: _____
Signature of Parent or Responsible Party: _____
Relationship to Patient: _____

ARTISTIC TOUCH™
DENTISTRY

Maryam Brazdo, DMD

DENTAL HISTORY

Date of Last Dental Visit:_____ Last Dental Cleaning:_____ Last Full Mouth X-rays:_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name:_____

Address:_____

City, State, Zip:_____

Telephone:_____

How often do you have dental examinations?_____

How often do you brush your teeth? How often do you floss?_____

Do you have any dental problems now?_____

If yes, please describe:_____

_____

Are any of your teeth sensitive to:

Hot or cold? **Yes No**
Sweets? **Yes No**
Biting or chewing? **Yes No**
Have you noticed any mouth odors or bad tastes? **Yes No**
Do you frequently get cold sores, blisters or any other oral lesions? **Yes No**

Do your gums bleed or hurt? **Yes No**
Have your parents experienced gum disease or tooth loss? **Yes No**
Have you noticed any loose teeth or change in your bite? **Yes No**
Does food tend to become caught in between your teeth? **Yes No**

Have you ever had:

Orthodontic treatment? **Yes No**
Oral surgery? **Yes No**
Periodontal treatment? **Yes No**
Your teeth ground or the bite adjusted? **Yes No**
A bite plate or mouth guard? **Yes No**
A serious injury to the mouth or head? **Yes No**

If so, please describe, including cause:_____

_____

_____

Do You:

Clench or grind your teeth while awake or asleep? **Yes No**
Bite your lips or cheeks regularly? **Yes No**
Hold foreign objects with your teeth? **Yes No**
(pencils, pipes, pins, nails, fingernails) **Yes No**
Mouth breathe while awake or asleep? **Yes No**
Have tired jaws, especially in the morning? **Yes No**
Smoke/chew tobacco? **Yes No**

Have you experienced:

Clicking or popping of the jaw? **Yes No**
Pain (joint, ear, side of face)? **Yes No**
Difficulty in opening or closing the mouth? **Yes No**
Difficulty in chewing on either side of the mouth? **Yes No**
Headaches, neck aches or shoulder aches? **Yes No**
Sore muscles (neck, shoulders)? **Yes No**

Are you satisfied with your teeth's appearance? **Yes No**

Do you feel nervous about having dental treatment? **Yes No**

If so, what is your biggest concern?_____

Have you ever had an upsetting dental experience? **Yes No**

If yes, please describe_____