Welcome to HORIZONS DENTAL

Last Name: ________________ Legal First Name: _____________ M.I. ___ Preferred Name: __________

Home Address: _________________________________ City: _____________ State: _____ Zip________

Home Phone: (___) __________ Work Phone: (___) ___________ Ext: ____ Cell Phone: (___) __________

E-Mail Address_______________________________@__________________

☐ Male ☐ Female

Drivers License #: ______________________________

☐ Single ☐ Married ☐ Divorced ☐Widow

DOB: ____/____/____ Age: _____ SS#:______-____-________

Employer: _________________________________How Long? ________ Occupation: __________________

Employer's Address: _____________________________City: _____________ State:_____ Zip______

Spouse's Name: __________________________ Who referred you to our office? _____________________

Emergency Contact ________________________________ Relation: ____________________________

Home Phone: (___) __________Work Phone: (___) ___________ Ext: ____ Cell Phone: (___) __________

Primary Dental Insurance Coverage

Subscriber Name: ____________________________________ DOB: ___/___/___ SS#:_____________

ID# _________________ Group #: _______________ Insured's Employer:___________________________

Insurance Company Name: _________________________________ Phone: (_____) ___________________

Secondary Dental Insurance Coverage

Subscriber Name: ____________________________________ DOB: ___/___/___ SS#:_____________

ID# _________________ Group #: _______________ Insured's Employer:___________________________

Insurance Company Name: _________________________________ Phone: (_____) ___________________

OVER ➡

MEDICAL HISTORY

***Do you have a medical condition that requires antibiotic pre-medication before dental treatment? ☐ Yes ☐ No**

Name of Medical Doctor ______________________________ phone: ______________________________

Please list **all** medications you are currently taking ____

____

Do you use tobacco? ☐ Yes ☐ No If so, how often? _________________

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ AIDS/HIV+
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Blood Thinners
- ☐ Cancer/Tumors
- ☐Cosmetic Surgery
- ☐Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches (Severe)
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation/Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ/TMD
- ☐ Tuberculosis TB
- ☐ Ulcers
- ☐ Venereal Disease

Please list any surgeries or medical conditions you have had: ____

____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Sulfa

☐ Dental anesthetics ☐ Foods: ____________________ ☐ Others: _________________________

Pharmacy Name & Location ____

For Women: Are you taking Birth Control Pills? ☐ Yes ☐ No How many children have you had? ___________

Are you Pregnant? ☐ Yes ☐ No If yes how many weeks? _________ Due Date: __________ Are you nursing? ☐ Yes ☐ No

Signature ____ Date _____/_____/_____

☐ Parent or Guardian ☐ Spouse

837 Seminole Rd. Suite 100
Muskegon, MI 49441

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ryan Brunworth
837 Seminole Rd. Suite 100
Muskegon, MI 49441

Telephone: (231) 780-4100

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 listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the content 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 health care 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: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may Refuse to Sign This Acknowledgement**

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ **Individual refused to sign**
- □ **Communications barrier prohibited obtaining the acknowledgement**
- □ **An emergency situation prevented us from obtaining acknowledgement**
- □ **Other (Please Specify)**

____

____

____

Dr. Ronald Leyder, Jr. ■ Dr. Logan White ■ Dr. Erin Charnley

837 Seminole Rd. Suite 100
Muskegon, MI 49441
231-780-4100
Fax 231-780-4101
E-mail: HorizonsDental@hotmail.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

I, ____, DOB ________-________-__________

hereby give my consent to the office of: ____ to release Protected Health Information related to my (and/or family) dental history, status, treatment, copies of my/our dental record(s) and x-rays. This information shall be released to the following:

____
(New dental office/doctor's name)

____
(New dental office address)

____
(New dental office email)

SIGNATURE:____________________________________ **DATE:** ________________
(parent or guardian if patient is a minor or disabled)

Names of <u>additional</u> family members whose records are to be released with this request are:

____

____

____

____

Patient Dental History

Name ____

Name of Previous Dentist ____

Date of Last Dental X-rays ____

How long since your last dental visit? ____

Reason for today's visit: □ Check-up □ Pain □ Other ___________________________________

Have you ever been treated for Periodontal Disease? ____________________________________

Have you had any complications or bad experiences at the dentist? _________________________

____

____

Please share any questions or concerns that you would like us to know about: _______________

____

____

Patient Name: ____

Birth Date:____________________

I HEREBY AUTHORIZE HORIZONS DENTAL TO SHARE:

Any and all information that relates to my dental health.

WITH THE FOLLOWING PEOPLE:

Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________

I understand that I may cancel this consent at any time (by writing to Horizons Dental), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider to share my information with someone. This authorization does not expire unless I cancel it in writing or request it be updated by signing a new form.

Signature: ____ Date: ___________________