SCOTT HARRIS, D.M.D., LLC
FORREST HARRIS, D.M.D.

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Cell): _____ (Home): _____ (Work): _____ Ext:_____

Preferred contact method: ☐Cell ☐Home ☐Work Email Address: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____
Street City State Zip Code

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

☐ Dental Office ☐ Website ☐ Social Media ☐ Other_____

Name of person or office referring you to our practice:

Medical History

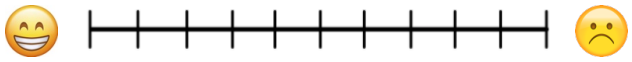
Date of Last Dental Visit: _____ Reason for this visit: _____

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

☐ Heart Disease or Failure
☐ Heart Attack, when: _____
☐ Chest Pain or Angina
☐ Irregular Heartbeat
☐ Rheumatic Fever
☐ Heart Murmur
☐ High Blood Pressure
☐ Cardiac Pacemaker
☐ Anemia
☐ Bleeding Problems
☐ Blood Transfusion in past
☐ Kidney Disease
☐ Thyroid Disease
☐ Hepatitis or Liver Disease
☐ Seizure, last occurrence: _____
☐ Stroke
☐ Jaw Joint Problems
☐ Contagious Diseases
☐ Hay fever / sinus problems
☐ Difficult breathing / other
☐ lung trouble
☐ Fainting spells
☐ High cholesterol
☐ Problems with immune system
☐ A tumor or growth
☐ Unplanned Weight Loss
☐ Any allergies
☐ Asthma, last attack: _____
☐ Emphysema or Bronchitis
☐ Pneumonia
☐ Tuberculosis
☐ Diabetes
☐ Pregnancy, Due date:_____
☐ Take recreational drugs
☐ Sickle Cell Disease
☐ Risk Factors for AIDS/HIV
☐ Sexually Transmitted Diseases
☐ Cancer
☐ Arthritis
☐ Alcohol or Drug Abuse
☐ Problems with Anesthesia
☐ Osteoporosis
☐ Osteonecrosis
☐ Steroid Therapy
☐ Stomach Ulcer
☐ Infectious mononucleosis
☐ Bruise easily
☐ Glaucoma
☐ Mental Disorders
☐ Sleep Disorder
☐ Low blood sugar
☐ You are on dialysis
☐ Delay in healing
☐ Chronic fatigue / night sweats
☐ A removable dental appliance
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

Medical History, Continued

- How do you feel about your smile?



- Do you smoke or vape? ☐ Yes ☐ No
  If yes, how many packs/pods day? _____ How many years? _____
- Do you have unhealed or inflamed areas, growths, or sore spots in or around your mouth? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any allergies? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- 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: _____
- Name of Physician: _____ Phone: _____
- Do you have a prosthetic joint/implant? ☐ Yes ☐ No
  If yes, where:_____ When: _____
- Do you have a heart valve replacement or history of bacterial endocarditis? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

_____

- Are you taking, or ever have taken, bone density meds or bisphosphomates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years? ☐ Yes ☐ No
  If yes, when?: _____
- Are you currently taking blood thinner medications? ☐ Yes ☐ No

Please list all the medications you are currently taking:
(if list is extensive, we will be happy to scan in your medication list)

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Responsible Party Information

☐ Check here if same as patient information

Patient Name: _____ Date: _____
Last First MI
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured (person whose name is on insurance): _____
Is insured a patient? ☐ Yes ☐ No Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name and Address: _____

_____

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

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name and Address: _____

_____

Consent and Financial Responsibility Form

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in treatment directly and indirectly; obtain payment from third party payers; conduct normal healthcare operations such as quality assessment and physician certification. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notices before signing this consent. I understand this organization has the right to change their Notices of Privacy Practices from time to time and that I may request a current copy at any time from the below address. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions. I understand that I may revoke this consent in writing anytime, except to the extent that you have taken, action relying on this consent.

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.

Adding Collection Fees to Account Balances

Agreement to Pay: I, the undersigned, accept the fee charged as a legal and lawful dept and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such is necessary.

Consent to Contact on Cell Phones and Emails

You agree, in order for us to service your account or to collect monies you may owe, Dr. Scott Harris, DMD, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read the above conditions of treatment, payment and contact and agree to their content:

_____ _____ _____

Signature of patient, parent or guardian Date Relationship to Patient

Please list below the other person/persons you would like to have access to your private information:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____