Carano Dental Group

We are pleased to welcome you to our practice. Thank you for filling out this form completely.

Patient Name: _____
(First) (Middle) (Last) (Preferred name)

Address: _____
Street City State Zip Code

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone #: (____)_____

Marital Status: _____ Social Security #: _____ Date of Birth: _____

Email: _____ Employer: _____

Other immediate family members at our office? _____

Who should we contact in case of an emergency? Name_____ Phone (___)_____

How did you hear about our office? _____

GUARANTOR (PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN ABOVE)

Name: _____ Social Security #: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Telephone Number: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: _____ Employer: _____
First Middle Last

Insured's Date of Birth: _____ Social Security/ID #: _____ Group #: _____

Insurance Company's Name: _____ Insurance Phone Number: _____

Insurance Address: _____

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I understand 24 hours notice is expected if I need to cancel an appointment, otherwise there may be a fee assessed. This fee is a minimum of $50 to a maximum of the cost of what was to be done for your appointment the day you missed. I also understand that any accounts over 30 days are subject to late and/or finance charges (18%APR). I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. It is my responsibility to notify your office of future changes. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I hereby authorize payment (directly to the dental office) of the group insurance benefits otherwise payable to me. I understand that any estimates given by Carano Dental Group for insurance coverage are estimates and that I am responsible to know my insurance policy. We file dental insurance as a courtesy for established patients. I must pay the estimated non-covered portion at the time of treatment, and whatever the insurance company does not pay is my responsibility to make up in a timely manner. We accept Visa, MasterCard, American Express, and Discover cards for your convenience. We do accept personal checks, however, returned checks are subject to a $35.00 NSF fee.

I have read, understand and agree to the information above.

Signature of responsible party_____**Date**_____

Relationship to patient if other than patient_____

DENTAL HISTORY

Date of last dental visit? _____ Date of last x-rays? _____
Dental Concerns? _____

MEDICAL HISTORY

Physician's Name _____ Physician's Phone _____
Have you had a serious illness or operation? Y ( ) N ( ) If yes, please describe_____
Are you currently under physician care? Y ( ) N ( ) If yes, please describe_____

Please check those conditions that have ever applied to you:

☐ Joint Replacement	☐ Rheumatic Fever	☐ Seizures
☐ Arthritis	☐ Shingles	☐ Epilepsy
☐ Sinus Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Abnormal Bleeding
☐ Alcohol Abuse	☐ Anemia	☐ Sexually Transmitted Disease
☐ Drug Abuse	☐ Asthma	☐ Blood Transfusion
☐ Cancer	☐ Chemotherapy	☐ Colitis
☐ Congenital Heart Defect	☐ Diabetes	☐ Difficulty Breathing
☐ Artificial Heart Valve	☐ Emphysema	☐ Sickle Cell Disease
☐ Heart Murmur	☐ Fainting Spells	☐ Fever Blisters
☐ Heart Surgery	☐ Glaucoma	☐ HIV+ Aids
☐ Heart Attack	☐ Frequent Headaches	☐ Hepatitis A
☐ Pace Maker - Date placed:_____	☐ Facial Surgery	☐ Hepatitis B
☐ Mitral Valve Prolapse	☐ High/Low Blood Pressure	☐ Hepatitis C
☐ Liver Disease	☐ Psychiatric Problems	☐ Hemophilia
☐ Kidney Problems	☐ Tobacco Use	☐ Radiation Therapy

Other:_____

ALLERGIES

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex
☐ Metals	☐ Penicillin	☐ Sulfa	Other:_____

Women Only

Are you taking Birth Control Pills? Y ( ) N ( )
Are you pregnant? Y ( ) N ( ) If yes, # of weeks: _____ Are you nursing? Y ( ) N ( )

MEDICATIONS (please list all that you are taking)

_____
_____
_____

Consent for use and disclosure of health information:

Please read the following statements carefully and ask if you have any questions.
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 the right to read our Notice of Privacy Practices before you decide whether to sign this consent. This notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information and of other important matters regarding your protected health information. A copy of this notice can be acquired simply by asking for it.

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, upon request. 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 at any time by contacted our office manager at:

1670 Lincoln Hwy E, Lancaster, PA 17602 Telephone: 717.394.1067

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact information listed above. Please understand that revocation of this content 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 continue treating you if you revoke this consent.

By signing below you agree that you have had full opportunity to read and consider the contents of this consent and your Notice of Privacy Practices. You also agree and understand by signing this consent form, you give your consent to use and disclose your protected health information to carry out treatment, payment activities and healthcare options.

Signature:_____ Date:_____

My dental information can also be given to:_____