HOWARTH
FAMILY DENTAL CENTER

CONSENT TO TREAT A MINOR

If the patient is a minor (under 18 years of age), please read and sign the following statement:

Patient's Name: _____

I hereby grant permission to the Howarth Family Dental Center and/or to the Dentist in charge of the above named minor child to administer any treatment, and such anesthetics as may be deemed necessary to properly treat my child.

I understand that I will be informed of the diagnosis, treatment, and possible risks and consequences of such treatment, and do authorize the Doctor(s) to proceed.

I also understand that I must be present in the office each time my child is treated, and that the parent or guardian requesting treatment is responsible for all fees for services rendered.

Parent or Guardian: _____

Today's Date: _____

Howarth Family Dental Center

Name_____ Date of birth _____Today's date_____

Instructions: Please read and review all questions. Answer all questions by circling yes, no, or unsure. All questions should be answered truthfully. Incorrect or omitted information may be dangerous to your health. Please explain any yes or unsure answers on the line provided. Please list medication names and dosages.

Name and phone number of physician(s):_____

1. Do you take any type of antibiotic?	Yes ☐	No ☐	Unsure _____
2. Do you take insulin?	Yes ☐	No ☐	Unsure _____
3. Do you take any type of heart medication?	Yes ☐	No ☐	Unsure _____
4. Do you take a diuretic?	Yes ☐	No ☐	Unsure _____
5. Do you take any type of blood thinner?	Yes ☐	No ☐	Unsure _____
6. Do you take any antidepressants?	Yes ☐	No ☐	Unsure _____
7. Do you take any tranquilizers?	Yes ☐	No ☐	Unsure _____
8. Do you take asprin, tylenol, or any pain medications?	Yes ☐	No ☐	Unsure _____
9. Do you take birth control pills?	Yes ☐	No ☐	Unsure _____
10. Do you take hormones, cortisone,or steriods?	Yes ☐	No ☐	Unsure _____
11. Do you use an inhaler?	Yes ☐	No ☐	Unsure _____
12. Do you take any cancer drugs?	Yes ☐	No ☐	Unsure _____
13. Do you take any other medications?	Yes ☐	No ☐	Unsure _____
14. Are you allergic to Novacaine?	Yes ☐	No ☐	Unsure _____
15. Are you allergic to Iodine?	Yes ☐	No ☐	Unsure _____
16. Are you allergic to Penicillin?	Yes ☐	No ☐	Unsure _____
17. Are you allergic to Sulfa drugs?	Yes ☐	No ☐	Unsure _____
18. Are you allergic to any other antibiotics?	Yes ☐	No ☐	Unsure _____
19. Are you allergic to Codeine?	Yes ☐	No ☐	Unsure _____
20. Are you allergic to asprin/Tylenol?	Yes ☐	No ☐	Unsure _____
21. Are you allergic to Barbiturates?	Yes ☐	No ☐	Unsure _____
22. Are you allergic to any narcotics?	Yes ☐	No ☐	Unsure _____
23. Do you have any other allergies?	Yes ☐	No ☐	Unsure _____
24. Have you ever had Rheumatic heart Disease?	Yes ☐	No ☐	Unsure _____
25. Have you ever had a congenital heart disease?	Yes ☐	No ☐	Unsure _____
26. Have you ever had a heart murmur?	Yes ☐	No ☐	Unsure _____
27. Have you ever had a heart attack?	Yes ☐	No ☐	Unsure _____
28. Have you ever had angina?	Yes ☐	No ☐	Unsure _____
29. Have you ever had heart surgery?	Yes ☐	No ☐	Unsure _____
30. Do you have a pacemaker?	Yes ☐	No ☐	Unsure _____
31. Have you ever had an irregular heart beat?	Yes ☐	No ☐	Unsure _____
32. Do you have a prosthetic heart valve?	Yes ☐	No ☐	Unsure _____
33. Have you ever had excessive bleeding?	Yes ☐	No ☐	Unsure _____
34. Do you have Hemophilia?	Yes ☐	No ☐	Unsure _____
35. Have you ever had anemia?	Yes ☐	No ☐	Unsure _____
36. Have you ever had low or high blood pressure?	Yes ☐	No ☐	Unsure _____
37. Have you ever had Asthma?	Yes ☐	No ☐	Unsure _____
38. Do you have breathing problems?	Yes ☐	No ☐	Unsure _____
39. Do you have a persistent cough?	Yes ☐	No ☐	Unsure _____
40 Have you ever had Tuberculosis?	Yes ☐	No ☐	Unsure _____
41. Have you ever undergone radiation treatment?	Yes ☐	No ☐	Unsure _____
42. Have you ever had chemotherapy?	Yes ☐	No ☐	Unsure _____
43. Have you ever had cancer?	Yes ☐	No ☐	Unsure _____
44. Have you ever had tumors or growths?	Yes ☐	No ☐	Unsure _____
45. Do you have Diabetes?	Yes ☐	No ☐	Unsure _____
46. Have you ever had a joint surgery?	Yes ☐	No ☐	Unsure _____
47. Do you have any internal plates or rods?	Yes ☐	No ☐	Unsure _____
48. Do you have any implants or prothesis?	Yes ☐	No ☐	Unsure_____
49. Do you wear a back brace?	Yes ☐	No ☐	Unsure _____
50. Have you ever had Hepatitis?	Yes ☐	No ☐	Unsure _____
51. Have you ever had liver disease?	Yes ☐	No ☐	Unsure _____
52. Have you ever had any kidney problems?	Yes ☐	No ☐	Unsure _____
53. Have you ever had kidney dialysis?	Yes ☐	No ☐	Unsure _____
54. Have you ever had a psychiatric disorder?	Yes ☐	No ☐	Unsure _____
55. Have you been treated by psychiatrist or counselor?	Yes ☐	No ☐	Unsure _____
56. Have you ever had depression or fatigue syndrome?	Yes ☐	No ☐	Unsure _____
57. Have you ever suffered a stroke?	Yes ☐	No ☐	Unsure _____
58. Have you ever had a seizure/Epilepsy?	Yes ☐	No ☐	Unsure _____
59. Have you ever suffered fainting spells?	Yes ☐	No ☐	Unsure _____
60. Do you have Arthritis?	Yes ☐	No ☐	Unsure _____

61. Have you been diagonised with AIDS/HIV? Yes ☐ No ☐ Unsure _____
62. Have you ever had Syphillis, Herpes, or Gonorrhea? Yes ☐ No ☐ Unsure _____
63. Have you ever had a serious head or neck injury? Yes ☐ No ☐ Unsure _____
64. Have you ever had a major operation? Yes ☐ No ☐ Unsure _____
65. Are you on a special diet? Yes No Unsure _____
66. Do you use smokeless tobacco products? Yes ☐ No ☐ Unsure _____
67. Have you ever used recreational drugs? Yes ☐ No ☐ Unsure _____
68. How much alcohol do you drink a week? _____ a week
69. How many packs of cigarettes do you smoke? _____ a day
70. Do you have any medical condition we should be aware of? _____ _____

For women:

71. Are you pregnant? Yes ☐ No ☐ Unsure _____
72. Are you breastfeeding? Yes ☐ No ☐ Unsure _____

DENTAL HISTORY

1. What dental problem brought you in today? _____
2. Do you have any dental concerns or complaints? Yes ☐ No ☐ Unsure _____
3.Are you worred about recieving dental care? Yes ☐ No ☐ Unsure _____
4. Any complications following dental treatment? Yes ☐ No ☐ Unsure _____
5.Are you happy with the appearance of your teeth? Yes ☐ No ☐ Unsure _____
6.Have you ever had an injury to your teeth, jaw, or face? Yes ☐ No ☐ Unsure _____
7.How often do you brush your teeth? _____ a day
8.How often do you floss? _____ a week
9.Is there fluoride in your dinking water? Yes ☐ No ☐ Unsure _____
10.Do you grind your teeth? Yes ☐ No ☐ Unsure _____
11.Do any of your teeth hurt? Yes ☐ No ☐ Unsure _____
12.Are your teeth sensitive to hot or cold? Yes ☐ No ☐ Unsure _____
13.Are any of your teeth becoming loose? Yes ☐ No ☐ Unsure _____
14.Any growths or sores in your mouth? Yes ☐ No ☐ Unsure _____
15.Have your teeth shifted? Yes No Unsure _____
16.Do your gums bleed? Yes No Unsure _____
17.Do you have any previous dental x-rays? Yes ☐ No ☐ Unsure _____
18.Date of last dental visit:_____
19.Reason for

I understand the need for these questions to be answered truthfully and to the best of my knowledge. The answers I have given are accurate. I also understand it is very important to report any change in my medical or dental status to the dentist at the earliest possible time and I agree to do so. I give my permission to the dentist to obtain from my personal physician any additional information regarding my medical history needed to provide me the best dental care treatment possible.

Person completing this form (signature)_____ Date_____

If other than patient, relationship_____

Reviewed by_____ Reviewed by_____ Reviewed by_____

MEDICAL HISTORY UPDATE

I have reviewed my/the patient's MEDICAL HISTORY. My/the patient's medical status and general health have changed as follows (if no change, write "No Change"_____

Signature of person completing this update:_____ Relationship to patient:_____

Update reviewed by:_____ Update reviewed by:_____

MEDICAL HISTORY UPDATE

I have reviewed my/the patient's MEDICAL HISTORY. My/the patient's medical status and general health have changed as follows (I

_____

Signature of person completing this update:_____ Relationship to patient:_____

Update reviewed by:_____ Update reviewed by:_____

Howarth Family Dental Center

Thank you for selecting our dental team. We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PERSONAL INFORMATION

Social Security No:_____Date:_____Referred by:_____
Patient's Name:_____ Preferred Name_____ Male □Female□ Minor □
Single □ Married□Divorced□ Separated□ Widowed□
Address_____City_____St_____Zip_____
HomePhone_____WkPhone_____Ext_____Pager_____
Date of Birth_____NCDL#_____Email:_____
Employer_____Occupation_____Emergency Contact:_____
_____Phone:_____
If Married, Name of Spouse: _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Social Security No:_____Relation to Patient:_____
Name:_____
Address:_____City_____St___Zip_____
Home Phone_____Wk Phone_____Ext_____Pager_____
Employer:_____Email_____
If Married, Name of Spouse: _____

For your convenience we offer these methods of payment, please check the option you prefer:
Cash___☐___ Check___☐___ Mastercard/Visa___☐___ Carecredit___☐___
Dental Fee Plan_____

INSURANCE INFORMATION

Employee's Name_____Relationship To Patient:_____
Employee's Birthdate:_____Employee's SS#_____
Employer:_____Occupation:_____
Insurance Company Name_____Group#_____
Effective Date of Coverage:_____Insurance Co Web Address:_____
Insurance Company Address for Claims:_____
_____

I hereby authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

STUDENT INFORMATION(COLLEGE)

Is patient a full time student_____Name of School_____

Kindly give us a 48 hour notice for cancellations, there will be a $50.00 charge for all cancellations without this notice.

Howarth Family Dental Center

Office Protocol
(Please review the following carefully.)

We welcome and encourage frank discussion of services and fees prior to treatment to avoid misunderstandings.

EMERGENCY AND NON-PATIENTS OF RECORD: payment in full is required at the time of service when you checkout.

FEES : Fees are based on the dental procedure rendered and the time spent with you.

PATIENTS OF RECORD WITH INSURANCE: Your insurance policy is an agreement between you and your insurance company. We are not a party to this agreement! No insurance company attempts to cover all dental costs. This office, as a courtesy, provides for your insurance claims to be processed in a timely manner at no cost to you, **allowing only your deductible and a 50% payment of balance to be paid at visits as opposed to paying the entire cost at the time of visit.** You must provide proof of insurance with an insurance card and benefits summary. If your insurance does not pay within sixty 60-days, payment is due in full. Any payment subsequently made by your insurance company in excess of the balance on your and your family's accounts will be refunded to you. Any balance due to plan limitations is your responsibility payable within 15 days.

Since we are not a party to the agreement with your insurance carrier, it is YOUR responsibility to check on any outstanding claims. It is not our policy to contact carriers to establish why they haven't paid or why they are paying less than anticipated.

NON-INSURANCE PATIENTS: payment is required in full at the time of service when you check out.

LATE CANCELLATION AND NO SHOW FEES: There is considerable financial overhead involved in managing this practice**. A 48-hour notice is required** to cancel or reschedule any appointments with our office. As a courtesy to you, we will call to remind you of your appointment however, it is ultimately your responsibility to keep your appointment. **Any appointments cancelled or rescheduled without this notice may be charged a $50.00 fee.** (i.e. if you have two appointments on the same day, one with hygiene and one with the doctor, you may be charged $50.00 per appointment.)

CHANGES IN PERSONAL DATA: It is important that this office be notified immediately of changes in patient information: insurance coverage, mailing address, telephone numbers. Any changes in insurance will require that a new assignment of benefits form be completed.

****This is to certify that I, the undersigned, agree to accept full responsibility for the payment of all fees and that I have read and understood, and agreed to the financial policy stated above.

Patient / Guardian Signature: _____Date: _____

HOWARTH FAMILY DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Social Security #: _____

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 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. 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 and revisions of our Notice, at any time by contacting:

Contact Person: Alice Johnson
Telephone: 919-876-5236 Fax: 919-878-9115
Email: AJ@howarthdental.com
Address: 3141-107 Capital Blvd. Raleigh, NC 27604

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

Howarth Family Dental Center

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 barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)