LafayetteFamilyDental
Oriana Suh, DMD

Patient Authorization Form

Lafayette Family Dental
500 N. 26th St.
Lafayette, IN 47904
765.448.1393

I give permission for the office of Dr. Oriana Suh to speak with:

_____ _____
(name of person) *(phone number)*
spouse/parent/guardian/other

_____ _____
(name of person) *(phone number)*
spouse/parent/guardian/other

About the following information:

- ☐ *Appointment information*
- ☐ *Financial information*
- ☐ *Dental information pertaining to your oral health*
- ☐ *Request of dental records*
- ☐ *All of the above*

-OR-

☐ *I **do not** give my permission to release information pertaining to my dental health*

_____ _____
Signature *Date*

Dental/Medical History

Lafayette Family Dental

Patient Name: _____

The following information is needed to enable us to give you the best possible treatment. In order for the doctor to thoroughly diagnose any condition, she/he must have accurate answers. This information is strictly confidential.

Dental History/Information

Previous Dentist _____ Telephone # _____

Date of last dental exam: _____ Date of last dental x-rays: _____

Have you been taught a method of brushing/flossing? O Yes O No

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

Reasons for today's visit: _____

Please check any of the following conditions that apply to you:

Please provide details about any positive answers below:

O Clicking or popping TMJ/joint	O Bad Breath	O Sensitivity to temperatures	O Sores in mouth
O Pain in TMJ/muscle tension in face or joint area	O Bleeding Gums	O Sensitivity to sweets	O Swelling in mouth/neck
	O Periodontal Treatment	O Sensitivity when biting	O Previous injury in mouth
O Grinding/clenching habit	O Loose/Broken Teeth	O Food collection between teeth	O Previous mouth surgery

Have you ever had an unusual reaction to any dental anesthetic? O Yes O No, Explain: _____

Have past dental experiences been satisfactory? O Yes O No, Explain: _____

Do you have any concerns/fears about dental treatment? O Yes O No, Explain: _____

Do you prefer nitrous oxide with treatment? O Yes O No

Medical History/Information

Physician: _____ Telephone # _____

Date of last physical exam:

Please list all medications you are currently taking as well as over the counter medications, herbals, vitamins, homeopathic remedies: (Continue on back of form, or attach a copy of a list of medications if necessary) _____

Allergies/reactions to medications or any other allergies? _____

(Women only)

Are you pregnant O Yes O No Nursing? O Yes O No Using any form of birth control medication? O Yes O No

Have you been hospitalized in the past year? O Yes O No _____

O Anemia	O Circulatory problems	O Hepatitis B or C	O Rheumatic fever/rheumatic
O Arthritis, rheumatism	O Cortisone treatments/steroids	O High blood pressure	O Heart disease
O Artificial heart valves	O Cough, persistent/chronic	O Low blood pressure	O Shortness of breath
O Artificial joints	O Cough up blood	O HIV positive	O Skin rash
O Asthma, sinus problems	O Diabetes	O AIDS	O Stroke
O Autoimmune disease	O Epilepsy/seizures	O Kidney disease	O Congestive heart failure
O Back Problems	O Fainting	O Mitral valve prolapse	O Thyroid disease
O Blood Disease	O Glaucoma/Eye disorders	O Malignancy/Tumor/Cyst	O Tobacco habit
O Abnormal bleeding, prolonged healing, bruise easily	O Headaches/migraines	O Nervous disorders	O Tuberculosis
	O Heart Murmur	O Pacemaker	O Ulcer/Digestive disorder
	O Heart disease (describe)	O Psychiatric care	O Venereal disease
O Cancer	O Hepatitis/liver disease	O Radiation treatment	O Hemophilia
O Chemical dependency	O Chemotherapy	O Respitory disease	

Are you presently under a physician's care? O Yes O No, Explain:

Do you consider yourself to be in good health? O Yes O No, Explain:

Please describe any impending operations, recent injuries or other information the doctor should be aware of:

Notice of Privacy Practice Acknowledgement HIPPA and Financial Policy
Lafayette Family Dental

HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 that treatment directly and indirectly.

Obtain payment from third-party payers.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time.

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatments. We are not a preferred care provider but we do file all insurance claims. Please provide all your insurance information to the front desk. We accept cash, checks, Visa, Mastercard, and Discover as forms of payment.

Unless canceled 24 hours in advance, our policy is to charge (at our discretion) for failed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

We may accept assignment of insurance benefits after your deductible is met. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the dental program you carry.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

The adult accompanying a minor or guardians of a minor are responsible for full payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the financial policy. I acknowledge and accept full financial responsibility for all services rendered. I understand that any balance due may be placed with a collection agency and I agree to pay any and all collection fees incurred. In the event of legal act, I agree to pay reasonable attorney fees and costs.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____