Fotene Gennatos D.D.S.

415 West 5th Street, Storm Lake, IA 50588

712-732-2277

PATIENT INFORMATION

Name (First, Middle, Last)_____Preferred Name_____

Address_____City_____State_____Zip_____

Sex: M____ F____ Single___ Married ____ Widowed ____ Divorced _____ Birthdate _____ _____

Cell Phone (_____)_____Work Phone (_____)_____Home Phone (_____)_____

Employer Name & Address _____

City_____ State _____ Zip Code _____

Best way to confirm appointments (___)Home, (___)Work, (___)Cell (___)Email Address _____

(___) Text Cell phone carrier? (__)US Cellular (__) Verizon (__) Other_____

We will schedule your next check up appointment prior to you leaving today.

Responsible Party (Please fill out if different from above)

Name of person responsible for payment _____Relationship to patient__self/spouse/parent/other____

Address if different _____City_____State_____Zip_____

Cell Phone (_____)_____ Work Phone (_____)_____ Home Phone (_____)_____

Employer Name & Address _____City_____ State _____ Zip Code_____

Dental Insurance Information (PLEASE DO NOT GIVE MEDICAL INFORMATION)

Name of Person with Insurance_____Relationship to patient__self/spouse/parent/other____

Address_____City_____State_____Zip_____

Birthdate_____Social Security # _____Date Employed _____Work Phone (___)_____

Employer Name_____ Insurance Phone_____

Insurance Name & Address _____

City_____ State _____ Zip Code_____

Additional Dental Insurance Information (PLEASE DO NOT GIVE MEDICAL INFORMATION)

Name of Person with Insurance_____Relationship to patient__self/spouse/parent/other____

Address_____City_____State_____Zip_____

Birthdate_____Social Security #_____Date Employed_ _____Work Phone (___)_____

Employer Name_____ Insurance Phone _____

Insurance Name & Address _____

City_____ State _____ Zip Code_____

Insurance Signature Card, Acknowledge Of Receipt Of Notice Of Privacy And Payment Policy

--I authorize direct payment of any benefits on my policy otherwise payable to me assigned to the provider involved in my care. I authorize release of any information necessary to process my claims. I understand that I am financially responsible to the provider involved in the claim for charges not covered by my insurance.

--I have received or been offered a copy of the Fotene Gennatos, DDS's Notice of Privacy Practices.

--I acknowledge that payment is due in FULL ON THE DAY OF SERVICE.

_____ _____

PRINT PATIENT'S NAME SIGNATURE TODAY'S DATE

_____ _____

Relationship to patient Reason we are unable to obtain signature

Patient Name:_____ Birthdate:_____

Dental History

Reason for today's visit_____ Date of last dental visit_____

Previous Dentist Name _____ Date of last dental x-rays_____

Mark (x) if you have or had problems with any of the following:

__Bleeding gums	___ Injury to teeth or jaw	___Periodontal treatment
__Clenching/grinding of teeth	___ Loose teeth/broken fillings	___Sensitivity to hot/cold
__Decayed teeth (cavities)	___ Painful or locking jaw	___Sores or swelling in mouth

Are you happy with your smile?_____

Medical History

Physician's Name_____ Date of last visit_____

WOMEN ONLY: Are you or might you be pregnant? _____Yes _____No

Mark (x) if you have had any of the following:

_____Artificial heart valve	_____Heart problems/Stroke	_____Nicotine Habit
_____Artificial joints	_____Hepatitis	_____ Pacemaker
_____ Cancer	_____ High Blood Pressure	_____Radiation Treatment
_____Congenital heart lesion	_____HIV/AIDS	_____ Rheumatic Fever
_____ Diabetes	_____Mitral Valve Prolapse	_____Tuberculosis (TB)

ALLERGIES

_____ NONE _____PENICILLIN _____LATEX _____ASPIRIN _____CODEINE _____Sulfa

_____OTHER ALLERGIES_____

MEDICATIONS

Are you taking blood thinners? _____ Are you taking bisphosphonates? _____

List each medication your are currently taking and why:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Today's Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

Medical Information Release Form
HIPAA Release Form

Name: _____ Date of Birth:_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____
☐ Parents _____
☐ Children _____
☐ Other _____

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call ☐ My Home ☐ My Work ☐ My cell Number _____ ☐ Text

If unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call

Signed _____ Date: _____
Witness: _____ Date: _____