Holmes Dental Associates
General & Cosmetic Dentistry
TMJ Disorders

Bloomington 309.662.0523
Farmer City 309.928.2727
www.holmesdentalassociates.com

Welcome to Holmes Dental Associates !

For your convenience you may print and fill out the necessary forms prior to your arrival.

Please bring with you to your initial appointment the following:

- The Patient Information Form (Adult or Child)
- The Health History Form
- The HIPAA / Records Release Consent Form
- Any oral appliances, bite splints, or retainers that you have
- Any dental radiographs, MRI, or CT scans that are less than one year old.
- Referral form (if you were given one from a referring doctor)
- Dental insurance card
- Medical insurance card

You will find office location maps, contact informaiton, and answers to most of your questions on our web site.

Please feel free to call us if you have any questions.

We look forward to meeting you !

Adult Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State: _____

Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Soc. Sec. #: _____- _____-_____

O Male O Female Email Address: _____

O Single O Married

Your Employer:_____ Occupation:_____

Do you have dental insurance through ***your*** employer? O Yes O No

Name of insurance company: _____ Your Ins. ID #: _____
(May not be same as SS#)

Spouse Information

Spouse's name:_____ Date of Birth: _____/_____/_____

Soc. Sec #: _____-_____-_____

Employer: _____ Occupation:_____

Does your spouse have dental insurance through ***his/her*** employer? O Yes O No Group #: _____

If yes, are you covered under your spouse's insurance? O Yes O No

Name of insurance company:_____ Spouse's Ins. ID#: _____
(May not be same as SS#)

Additional Information

Who referred you to our office?_____

In case of emergency, contact:_____ (_____)_____-_____
Name Phone Number

Your signature authorizes the release of information to your insurance company and it authorizes the assignment of benefits. **Patients are responsible for all costs not covered by their insurance company.** There is a 2% monthly finance charge on overdue accounts. Your signature also authorizes the use of your records and clinical photographs for scientific publication or teaching provided your name remains anonymous.

X_____ _____/_____/_____
Signature Date

Updated: _____ _____ _____ _____ _____
Date and Initials

_____ _____ _____ _____ _____

Child Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State: _____

☐ Male ☐ Female Zip Code: _____

Soc. Sec #: _____-_____-_____ Home Phone: (_____) _____-_____

Parent/Guardian Email Address: _____

Fathers Name: _____ Date of Birth: _____/_____/_____

Employer:_____ Work Phone: ( ) _____-_____

Social Security #: _____-_____-_____ Cell Phone: ( ) _____-_____

Does ***father*** have dental insurance through ***his*** employer? ☐ Yes ☐ No
If yes, is child covered under ***father's*** insurance? ☐ Yes ☐ No

Name of insurance company: _____ Group #: _____

Father's Ins. ID #: _____ Child's Insurance ID # _____
(May not be same as SS#) (May not be same as SS#)

Mother's Name: _____ Date of Birth: _____/_____/_____

Employer:_____ Work Phone: ( ) _____-_____

Social Security #: _____-_____-_____ Cell Phone: ( ) _____-_____

Does ***mother*** have dental insurance through ***her*** employer? ☐ Yes ☐ No
If yes, is child covered under ***mother's*** insurance? ☐ Yes ☐ No

Name of insurance company: _____ Group #: _____

Mother's Ins. ID #: _____ Child's Insurance ID # _____
(May not be same as SS#) (May not be same as SS#)

Additional Information

Name of School : _____ City/State: _____

Who referred you to our office?_____

In case of emergency, contact:_____ (_____)_____-_____
Name Phone Number

Your signature authorizes the release of information to your insurance company and it authorizes the assignment of benefits. **Patients are responsible for all costs not covered by their insurance company.** There is a 2% monthly finance charge on overdue accounts. Your signature also authorizes the use of your records and clinical photographs for scientific publication or teaching provided your name remains anonymous.

X_____ _____/_____/_____
Signature of Parent/Guardian Date

Updated: _____ _____ _____ _____
Date and Initials

_____ _____ _____ _____

Health History

Patient Name: _____ Date of Birth: _____/_____/_____ Weight: _____

1. Mark all of the following for which you have or have had:

___ High Blood Pressure
___ Heart Murmur
___ Prolapsed Mitral Valve
___ Artificial Heart Valve
___ Heart Attack
___ Heart Surgery
___ Congenital Heart Disease
___ Congenital Heart Defect
___ Infective Endocarditis
___ Pacemaker
___ Angina
___ Artificial Joint(s)
Date Joint(s) placed: _____
___ Cancer
Type of cancer and status: _____

___ Stroke
___ Diabetes
___ Kidney Disease
___ Liver Disease
___ Hepatitis A,B,or C
___ Tuberculosis
___ Alzheimer's Disease
___ Hemophilia
___ Psychiatric Treatment
___ Depression
___ Rheumatic Fever

___ Thyroid Disorder
___ Epilepsy
___ Asthma
___ Asthma Inhaler
___ HIV
___ AIDS
___ Drug Addiction
___ Currently Nursing
___ Currently Pregnant
___ Jaw Joint Popping
___ Jaw Joint Pain

List Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

2. Have you had any serious condition, disease, or illness not listed above? If yes, what? _____

_____

3. Name, City, and Phone number of your personal physician: _____

4. Are you allergic to penicillin? _____ Are you allergic to any other drugs or anything else? _____

_____

5. What concerns do you have about your dental health? _____

6. Are you happy with the appearance of your smile?_____ If not, why? _____

_____

7. Have you had any problems with any previous dental care? _____ If yes, what? _____

_____

8. Do you smoke? _____ Do you use smokeless tobacco? _____

9. When was your last dental exam? _____ Is it important for you to keep your teeth? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner and I have answered all questions truthfully and fully. If further information is needed from another health care provider, you have my permission to contact them and request release of all necessary information. I will notify you of any changes in my health or medication.

X _____ _____/_____/_____
Signature of patient or parent/guardian if patient is a minor Date

My initials indicate I have reviewed the information above and made any necessary changes.

_____ _____ _____ _____ _____ _____
Date and Initials

_____ _____ _____ _____ _____ _____

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Notice of Privacy Practices

OUR LEGAL DUTY

We are requred by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April, 14, 2013 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in privacy pracitices we will change this notice and make the new notice available upon request.

You may request a physical copy of our notice at any time.

Release of Information / Records Consent

I consent to release and discussion of my dental records and information to the following people:

1. _____

2. _____

3. _____

X_____
Printed Name

X_____ _____
Signature of patient (parent /guardian if patient is a minor) 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
- □ Communication barrier prohibited
- □ An emergency situation prevented
- □ Other: _____