

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 information, 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 <i>your</i> employer?	O Yes O No		
Name of insurance company:	Your Ins. ID #:(May not be same as SS#)		
Spouse Information			
Spouse's name:			
Soc. Sec #:			
Employer:	Occupation:		
Does your spouse have dental insurance through <i>his/her</i>	r 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#)		
Additiona	al Information		
Who referred you to our office?			
•			
In case of emergency, contact:Name	Phone Number		
Patients are responsible for all costs not covered by their in	asurance company and it authorizes the assignment of benefits. Insurance company. There is a 2% monthly finance charge on our records and clinical photographs for scientific publication or		
X	/ /		
Signature	Date		
Updated:			



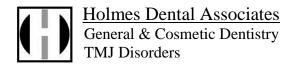
Child Patient Information

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 <i>father</i> have dental insurance through <i>his</i> employed If yes, is child covered under <i>father's</i> insurance?	rer? □ Yes □ No □ Yes □ No
Name of insurance company:	-
Father's Ins. ID #:(May not be same as SS#)	Child's Insurance ID #(May not be same as SS#)
Mother's Name:	Date of Birth:/
Employer:	Work Phone: ()
Social Security #:	Cell Phone: ()
Does <i>mother</i> have dental insurance through <i>her</i> employ If yes, is child covered under <i>mother's</i> insurance?	yer?
Name of insurance company:	Group #:
Mother's Ins. ID #:(May not be same as SS#)	Child's Insurance ID #(May not be same as SS#)
<u>Addition</u>	nal Information
Name of School :	City/State:
Who referred you to our office?	
In case of emergency, contact:Name	
Patients are responsible for all costs not covered by their	insurance company and it authorizes the assignment of benefit insurance company. There is a 2% monthly finance charge of your records and clinical photographs for scientific publication
X	/
Signature of Parent/Guardian	Date
Updated: Date and Initials	



Health History

Patient Name:	Γ	Date of Birth:/_	/ Weight:
Mark all of the following for wh High Blood Pressure Heart Murmur Prolapsed Mitral Valve Artificial Heart Valve	ich you have or have had Stroke Diabetes Kidney Disease Liver Disease		List Current Medications 1 2 3
 Heart Surgery Congenital Heart Disease Congenital Heart Defect Infective Endocarditis Pacemaker 	Tuberculosis Alzheimer's Disease Hemophilia Psychiatric Treatment Depression Rheumatic Fever	AIDSDrug AddictionCurrently NursingCurrently PregnantJaw Joint PoppingJaw Joint Pain	4.
2. Have you had any serious condition			
3. Name, City, and Phone number of g4. Are you allergic to penicillin?			ng else?
5. What concerns do you have about y6. Are you happy with the appearance			
7. Have you had any problems with a	ny previous dental care?	If yes, what?	
3. Do you smoke? Do you			
I understand the above information is	necessary to provide me with er information is needed from	h dental care in a safe and m another health care pro	r you to keep your teeth?
X		/	/
Signature of patient or parent/s	guardian if patient is a minor		te
My initials indicate Date and Initials	I have reviewed the informa	ation above and made any	y necessary changes.



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Notice of Privacy Practices

OUR LEGAL DUTY

We are required 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 practices 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 a	and information to the following people:
1	
2	
3	
V	
XPrinted Name	
X	
XSignature of patient (parent /guardian if patient is a minor)	Date
For Office Use On	dv
We attempted to obtain written acknowledgement	•
but acknowledgement could not be obtained becau	<u> </u>
☐ Individual refused to sign	
☐ Communication barrier prohibited	
□ An emergency situation prevented□ Other:	
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