Dental Designs by Holst & Associates
401 East Robinson
Knoxville, IA 50138
(641) 828-8778

DENTAL DESIGNS
KNOXVILLE
DENTAL ASSOCIATES

PATIENT INFORMATION

PERSONAL INFORMATION

Patient's Name _____
LAST FIRST MIDDLE

Patient's Address: Street, Apt # _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-mail _____ Name of Spouse or Parent if minor _____

Best way to contact you? ❒Home Phone ❒Cell ❒Text ❒Email

Social Security # _____ Date of Birth _____ Marital Status: ❒Single ❒Married
MONTH / DAY / YEAR

Employer _____ Occupation _____

Business Address: Street, Apt # _____ City _____ State _____ Zip _____

Preferred Pharmacy _____ Pharmacy Phone # _____

Previous Dentist _____ Referred By _____

Physician's Name _____ Physician's Phone # _____

Name of Emergency Contact _____ Phone # _____

Referred by: ❒Radio ❒Newspaper ❒Phonebook ❒Website ❒Facebook ❒Friends or Family _____

INSURANCE

1. Do you have insurance that may cover any part of our service? ❒Yes ❒No

Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____
MONTH / DAY / YEAR

Policy Holder's Address: Street, Apt # _____ City _____ State _____ Zip _____

2. Are you covered under more than one policy? ❒Yes ❒No

Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____
MONTH / DAY / YEAR

Policy Holder's Address: Street, Apt # _____ City _____ State _____ Zip _____

ASSIGNMENT

I hereby assign all dental benefits which I am entitled to Dental Designs. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient or Guardian Signature _____ Date _____

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DENTAL HISTORY | SMILE EVALUATION

Date _____ Patient Name _____

DENTAL INFORMATION

1. Please state briefly the reason for your visit? _____
2. How long since your last dental visit? _____
3. ❒Yes ❒No Do your gums bleed, feel tender or irritated? _____
4. ❒Yes ❒No Are your teeth sensitive to hot, cold or sweets? _____
5. ❒Yes ❒No Are any teeth loose? _____
6. ❒Yes ❒No Do you grind, clench or grit your teeth? _____
7. ❒Yes ❒No Does your jaw ever click or cause pain on opening or closing? _____
8. ❒Yes ❒No Did you ever wear braces? _____
9. ❒Yes ❒No Have you ever worn any dental appliances? _____
10. ❒Yes ❒No Have you ever had gum treatments? _____
11. ❒Yes ❒No Do you wear dentures or plates? _____
12. ❒Yes ❒No Do you floss your teeth? _____
13. ❒Yes ❒No Have you ever had any unpleasant dental experiences or anything about dentistry you strongly dislike?

_____

SMILE EVALUATION

14. ❒Yes ❒No Do you like the way your teeth look? Why? _____
15. ❒Yes ❒No Are you happy with the color of your teeth? Why? _____
16. ❒Yes ❒No Would you like for your teeth to be whiter? Explain _____
17. ❒Yes ❒No Would you like for your teeth to be straighter? Explain _____
18. ❒Yes ❒No Do you have spaces between your teeth that you want closed? Explain _____

_____

19. ❒Yes ❒No Do you like the shape of your teeth? Explain _____
20. ❒Yes ❒No Do you have missing teeth that you would like to replace? Explain _____

_____

21. ❒Yes ❒No Do you have old silver fillings that you would like to replace with tooth-colored fillings? Explain _____

_____

22. ❒Yes ❒No Would you like to know more about any of our products or services? Explain _____

_____

23. If you could change anything about your smile, what would you change? _____

_____

_____

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. ❒Yes ❒No Are you under a physician care now? Why?_____Date of last physical examination?_____
2. ❒Yes ❒No Have you ever been hospitalized or had a major operation? Please list:_____
3. ❒Yes ❒No Have you ever had a serious head or neck injury? Please list:_____
4. ❒Yes ❒No Are you taking any medications, pills, vitamins, herbs or drugs? Please list:_____
5. ❒Yes ❒No Do you take or have you ever taken Phen-Fen or Redux? When?_____
6. ❒Yes ❒No Have you ever taken Fosamax, Boniva, Actonal or any other medications containing bisphosphonates?
7. ❒Yes ❒No Are you on a special diet? Describe:_____
8. ❒Yes ❒No Do you use tobacco? Please list:_____
9. ❒Yes ❒No Do you use controlled substances? Please list: _____
10. ❒Yes ❒No WOMEN: Are you now or trying to get pregnant? ❒ Nursing? ❒ Taking oral contraceptives?
11. Who is your preferred Pharmacy?_____ Phone Number_____
12. Are you allergic to any of the following:
    ❒Aspirin ❒Penicillin ❒Codeine ❒Acrylic ❒Metal ❒Latex ❒Local Anesthetics ❒Sulfa Drugs ❒Other
    Type of reaction:_____
13. Do you have or have you had any of the following:

❒AIDS/HIV Positive	❒Cold Sores/Fever Blisters	❒Gastric Reflux | GERD	❒Irregular Heartbeat	❒Scarlet Fever
❒Alzheimer's Disease	❒Congenital Heart Disorder	❒Genital Herpes	❒Kidney Problems	❒Shingles
❒Anaphylaxis	❒Convulsions	❒Glaucoma	❒Leukemia	❒Sickle Cell Disease
❒Anemia	❒Cortisone Medicine	❒Hay Fever	❒Liver Disease	❒Sinus Trouble
❒Angina	❒Diabetes	❒Heart Attack/Failure	❒Low Blood Pressure	❒Snore | Sleep Apnea
❒Arthritis/Gout	❒Drug Addiction	❒Heart Defibrillator*	❒Lung Disease	❒Spina Bifida
❒Artificial Heart Valve*	❒Easily Winded	❒Heart Murmur*	❒Mitral Valve Prolapse*	❒Stomach/Intestinal Disease
❒Artificial Joint*	❒Eating Disorder	❒Heart Pacemaker*	❒Osteoporosis	❒Stroke
❒Asthma	❒Emphysema	❒Heart Troubles/Disease	❒Pain in Jaw Joints	❒Swelling of Limbs
❒Blood Disease	❒Epilepsy or Seizures	❒Hemophilia	❒Parathyroid Disease	❒Thyroid Disease
❒Blood Transfusion	❒Excessive Bleeding	❒Hepatitis A	❒Psychiatric Care	❒Tonsilitis
❒Breathing Problem	❒Excessive Thirst	❒Hepatitis B or C	❒Radiation Treatments	❒Tuberculosis
❒Bruise Easily	❒Fainting Spells/Dizziness	❒Herpes	❒Recent Weight Loss	❒Tumors or Growths
❒Cancer	❒Frequent Cough	❒High Blood Pressure	❒Renal Dialysis	❒Ulcers
❒Chemotherapy	❒Frequent Diarrhea	❒High Cholesterol	❒Rheumatic Fever*	❒Venereal Disease
❒Chest Pains	❒Frequent Headaches	❒Hives or Rash	❒Rheumatism	❒Yellow Jaundice
		❒Hypoglycemia		*Condition may require medication

14. ❒Yes ❒No Have you ever had any serious illness not listed above? Please list:_____
15. Do you have any comments? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Name (Please print)_____ Date _____

Patient or Guardian Signature_____ Date _____

Reviewing Dentist Signature _____ Date _____

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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.

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

Patient, Parent or Guardian Signature_____

Patient Name (Please Print) _____ Date:_____

I also understand that if I have questions or complaints, I may contact:

Dr. Lisa Holst
401 East Robinson
Knoxville, IA 50138

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Call our office at (641) 828-8778 for their contact information.

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)

_____

_____

_____

Attempt was made by:_____ Date:____/____/____

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CONSENT AND AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT AUTHORIZATION

I,_____,hereby authorize the release, use or disclosure of my health Information as follows:

This authorization pertains to the following type of medical information about me: [Dental and Medical]

I hereby authorize Dental Designs to release the above described information to the following individual and/or organization:

_____

_____

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I also understand that I may revoke this information at any time by providing written notification to:
Dr. Lisa Holst | 401 East Robinson | Knoxville, IA 50138

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon the authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on [until revoked]. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient above, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient, Parent or Guardian Signature_____ Relationship:_____

Patient Name (Please Print)_____ Date _____

FOR OFFICE USE ONLY

Received by: _____ Date:____/____/____

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RECORD RELEASE FORM

I, _____ hereby authorize
(PATIENT'S FULL NAME)

Dentist's Name _____

Dentist's Address _____

_____

_____

to provide the office of Dental Designs with copies of my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examination, findings, treatments, prognosis and copies of any and all other records including x-rays, which pertain to me.

Patient or Guardian Signature_____ Date _____