~ Confidential ~ **ACQUAINTANCE FORM** *~ Confidential ~*

DATE:_____

☐Dr. ☐Mr. ☐Mrs.
☐Ms. ☐Miss _____
Last First Middle

Address:_____
Street City State Zip Code

Birthdate:_____ E-mail Address:_____

Employer/Occupation:_____

Phone #1: (_____) _____ cell / home / work Phone #2: (_____) _____ cell / home / work

Pharmacy Name, City: _____ Pharmacy Phone #: (_____) _____

By whom were you referred? _____

DENTAL HISTORY

What is your immediate dental concern? _____

General Dentist _____ Dental Specialists_____

MEDICAL HISTORY

Family Physician _____ Location_____

Additional Physicians _____

- Please list medical conditions you are currently being treated for or take medications for:

_____

_____

- Please list your medications, vitamins, and supplements below:

Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____

- Please list any major operations you have had: _____
- Have you been told to pre-medicate with antibiotics for dental care? ☐ Yes, with: _____ ☐ No
- Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____
- Do you take a daily aspirin? ☐ Yes ☐ No If yes, how much? _____
- Do you use tobacco products? ☐ Yes ☐ No If yes, how much? _____
- Have you taken every bisphosphonates or immunosuppressive meds? ☐ Yes, _____ ☐ No
- Have you ever had a problem with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart trouble/murmur	☐	☐	Diabetes	☐	☐	Nervous Disorders	☐	☐	Cancer
☐	☐	Rheumatic fever	☐	☐	Stroke	☐	☐	Asthma/Hay fever	☐	☐	Arthritis
☐	☐	High/low blood pressure	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Alcohol
☐	☐	Chest pains/shortness of breath	☐	☐	Dizziness/Fainting	☐	☐	Infectious Hepatitis	☐	☐	Bulimia/Anorexia
☐	☐	Swollen ankles	☐	☐	Headaches	☐	☐	HIV	☐	☐	Recreational Drugs

---

Head and neck exam:
•Tongue •Nodes
•Throat •Skin

BP =

Patient's Signature _____

Doctor's Signature _____

FINANCIAL RESPONSIBILITY FORM

~ Confidential ~

For your convenience, we accept cash, personal check, Visa, MasterCard, and Discover. Beyond the initial consultation appointment, we ask that fees be discussed prior to care as payment will be due at the time of service. To meet the needs of our patients, Maki Ishii, DMD, P.C. participates in various Dental PPO insurance programs, but insurance is not necessary to receive treatment at our office. Each insurance carrier has its own specific guidelines regarding the patient's financial responsibility. While we will work with you and your insurance carrier to reach your periodontal goals, we expect our patients to understand and acknowledge their financial responsibilities listed below:

- Payment for all services rendered is your financial responsibility.
- Please provide your complete insurance information at the bottom of the page. We will submit our charges to your insurance carrier for payment. You are responsible for all charges if you do not provide complete and accurate insurance information.
- *If our practice is one of your network providers*, you are responsible for paying your co-payments, deductibles, and coinsurance along with charges for non-covered items or services when services are rendered. Pre-treatment estimates can be obtained through your insurance company upon request. Your insurance company will mail you such a statement 2-6 weeks after your treatment plan has been determined and submitted. You may choose to complete procedures without this statement. Our experienced staff will determine an estimate of fees which will be due on the date of service. After your insurance carrier processes your claim, a bill will be generated for any remaining balance. If your insurance claim notifies us that you have overpaid, a reimbursement will be issued as a check and mailed to the address you provide on your Acquaintance Form unless otherwise specified.
- *If our practice is an out-of-network provider,* you are responsible for all charges when services are rendered. Please ask us for a financial estimate of treatment prior to treatment or inform us if you would like to receive a pre-treatment estimate from your insurance carrier. Your insurance company will mail you a statement with an estimate of how much they will reimburse you 4-6 weeks after your treatment plan has been determined and submitted.
- Please understand that financial estimates are only estimates and are not a contract. Treatment plans can change during procedures, and insurance payments can change during final processing. We will do our best to communicate before, during, and after a procedure regarding possible changes.

All patients are required to sign an acknowledgement of their financial responsibility. In the event you choose not to sign the acknowledgment of responsibility, Maki Ishii, DMD, P.C. reserves the right to withhold treatment. Please discuss any questions or concerns with our staff.

Signed: _____ Date: _____

PRIMARY DENTAL INSURANCE: _____

Name of Insured: _____

Your Relationship to Insured: _____

Employer of Insured: _____

Insured's Address: _____

Insured's Telephone: (_____)_____

Birthdate of Insured: _____

Social Security # or ID # of Insured: _____ Group Number: _____

SECONDARY DENTAL INSURANCE: _____

Name of Insured: _____

Your Relationship to Insured: _____

Employer of Insured: _____

Insured's Address: _____

Insured's Telephone: (_____)_____

Birthdate of Insured: _____

Social Security # or ID # of Insured: _____ Group Number: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name (Please Print) : _____ Date of Birth: _____

Home Address : _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and to work with your insurance carrier.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature and Acknowledgement of Receipt of Notice of Privacy Practices: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I give permission for this office to leave messages on any personal home phone, cell phone, or e-mail.

Signature:_____ **Date:**_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____