MORGAN
DENTAL CARE

Permission to Release Information

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak to regarding your medical and/or financial information.

Start date: ____________________________ End date: ___________________________

I, ______________________________ hereby grant the treating doctors and staff of Morgan-

(Patient Name)

Hill Dental Care my permission to speak with the following people regarding my health and dental condition.

1. Name: _________________________________ Relationship: _________________________
   Telephone: _________________ _____________________ __________________
   Home Work Cell
2. Name: _________________________________ Relationship: _________________________
   Telephone: _________________ _____________________ __________________
   Home Work Cell

The following information may be given to the above individual(s)
(please check all applicable boxes)

____ Appointment Time
____ Financial Information
____ Test/Lab Results
____ Medications
____ Procedures
____ Other Information regarding my health

(I understand I may revoke this consent at any time by giving written notice to Morgan-Hill Dental Care

Signed: ______________________________ Date: __________________________

Printed Name: ____

94 Main Street Gorham, Maine 04038
207-839-2655 207-839-5828 fax
MorganDentalCare.com DrMorgan@gwi.net

MORGAN DENTAL CARE

PATIENT CONSENT FORM HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that the organization has the right to change its Notice of Privacy Practices form time to time and that I may contact the organizations at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ______________________________________

Date: ____

MORGAN DENTAL CARE

If you have dental insurance you would like us to help you with, please notify us ***before*** *you are seen for your appointment.*
Thank You

ABOUT THE PATIENT

Today's Date ______________________

Patient Name ______________________
First Last

Name Prefer To Be Called ______________________

Male Female Non-Binary

Mailing Address ______________________
Street/Box #/Apt #

____
City State Zip

Home Phone ______________________

Work Phone ______________________ ext ______

Cell Phone ______________________

Email ______________________

Date of Birth ______ - ______ - ______

Social Security # ______ - ______ - ______

Circle Marital Status:

Single Married Widowed Partnered Divorced

Employer Name ______________________

Employer Address ______________________

____

Are you a full time student? ______________

If Yes, Name and Address of School ______________

____

Who should we contact in case of an emergency?

______________ Relationship to you ________

Phone Number ______________________

Name of Physician ______________________

Physician Phone Number ______________________

Office Location ______________________

SPOUSE OR PARENT INFORMATION

Name ______________________
First Last

Relationship to Patient: ______________________

Address ______________________
Street/Box #/ Apt. #

____
City State Zip

Home Phone ______________________

Cell Phone ______________________

Employer Name ______________________

Employer Address ______________________

____

Work Number ______________________ ext ______

Date Of Birth ______ - ______ - ______

Social Security # ______ - ______ - ______

HOW DID YOU HEAR ABOUT US?

__ Mailing ___Radio ___Website ___TV

__Yellow Pages ___Sign ___ Patient *

* If someone referred you, please list their name & relationship to you ______________________

DENTAL INFORMATION ON PATIENT

Please check if you have any of the following problems:

__Discomfort, clicking or popping in jaw
__Red, swollen or bleeding gums
__Sensitive tooth, teeth or gums
__Blister/sores in or around mouth
__Broken/chipped tooth or teeth
__Bad Breath __ Locking jaw __ Stained Teeth
__Ringing in ears __ Grinding Teeth
__Unhappy with the appearance of your teeth

If yes, explain what you are unhappy with:

____

____

____

Name of previous dentist? ______________________

Do your parents have gum disease or have they lost teeth due to gum disease?______________

Have you ever used a C-PAP? ______________

Has C-PAP ever been recommended to you?________

Ever been told you stop breathing in your sleep?______

Do you ever wake up gasping?______________

Are you often tired during the day?______________

Fall asleep during the day?______________

Do you have headaches in the morning?______________