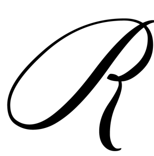

ROSEWOOD
DENTAL, PLC

PATIENT INFORMATION

Patient's Full Name____ Nickname or "Goes by"________________________

Birth Date______/______/______ Preferred Phone Number ___________________________

Emergency Contact, someone not living with the patient: Name_______________________________ Phone________________________

WE WANT TO HELP YOU GET THE SMILE YOU'VE ALWAYS WANTED

1. What is your present dental problem or concern?____

2. How do you feel about getting and maintaining a healthy smile?____

3. Would you like to know more about fresh breath?____

4. Are you pleased with the appearance of your teeth when you smile?____

5. Are there spaces between your teeth that you don't like?____

6. Are you pleased with the color of your teeth?____

7. Are you pleased with the shape of your teeth?____

8. Are you pleased with the appearance of your gums when you smile?____

9. Are your teeth...

   Chipped?____

   Protruding?____

   Hidden?____

   Crowded?____

10. Do you like the way your teeth fit together when you bite?____

11. Are there old fillings or dental treatments that you aren't happy with?_______________________________________

12. If you could change anything about the appearance of your smile, what would that be?__________________________

____

13. Is there anything about the shape or alignment of your jaw that you are not happy with?__________________________

____

14. Have you ever had a serious/difficult problem associated with any previous dental work?_________________________

____

15. Do you experience stress or anxiety when you visit a dental office?____

Please review and sign the Privacy Notice on the back of this form. Thank you!

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Rosewood Dental, PLC for the purposes of diagnosing for or providing treatment to me, obtaining payment for my dental care bills or to conduct healthcare operations of Rosewood Professional Center. I understand that diagnosis for or treatment of me by a dentist or hygienist at Rosewood Dental, PLC may be conducted upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of Rosewood Dental, PLC. Rosewood is not required to agree to the restrictions that I may request. However, if Rosewood Dental, PLC agrees to a restriction that I request, the restriction is binding on Rosewood Dental, PLC and any dentist or hygienist practicing in Rosewood Professional Center.

I have the right to revoke this consent, in writing, at any time, except to the extent that one of the Rosewood Dental, PLC dentists or Rosewood Dental, PLC has taken action in reliance on this consent.

My **"protected health information" means** health information, including demographic information, collected from me and created or received by my dentist, another healthcare provider, a dental insurance plan, or my employer. This protected health information relates to my past, present or future physical or mental health or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Rosewood Dental, PLC's Notice of Privacy Practices prior to signing this document. The said Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my dental bills, or in the performance of healthcare operations of Rosewood Dental, PLC. The said Notice of Privacy Practices is provided by the Rosewood Dental Team upon my request. The said Notice of Privacy Practices also describes my rights and Rosewood Dental, PLC's duties with respect to my protected health information.

Rosewood Dental, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy be sent in the mail, or by asking for one while in the office.

____	___________________________
Signature of Patient or Personal Representative	Date of Signature
____	___________________________
Printed Name of Patient or Personal Representative	Relationship to Patient, if Representative