



PATIENT INFORMATION

Patient Name (First, Middle, Last)

Date

Address

City

State

Zip

____ - ____ - ____
SSN

Date of Birth

Mobile/Home Phone #

Circle One: Minor Single Married Divorced Widowed Separated

Employer

Work Phone #

Emergency Contact Name

Relationship

Phone #

Name of Representative/Guardian

Relationship

How Did You Hear About Us?

ACKNOWLEDGMENT OF PAYMENT AT TIME OF SERVICE

*We are not contracted with any insurance company. We are an **Out of Network** provider. Payment is due at the time of service. We accept credit cards, checks, cash and care credit. As a courtesy, we can bill most insurances. We are unable to bill medi-cal, medicaid and HMO's. Payment will be made at time of service. Your insurance will send a check directly to you. It's your responsibility to check with your insurance to determine your **Out of Network** benefits.*

I hereby acknowledge that I have completely read the foregoing and have discussed any questions or concerns that I may have regarding the payment policy of Jeffrey S. Morley DDS.

Signature of Patient/Representative

Date

INSURANCE INFORMATION

Name of Subscriber

Relationship

_____-_____-_____
SSN

DOB

Policy ID

Insurance Company

Employer/Group ID

Phone # (*on back or card*)

Name of Insured (*if different*)

SECONDARY

Name of Subscriber

Relationship

_____-_____-_____
SSN

DOB

Policy ID

Insurance Company

Employer/Group ID

Phone # (*on back or card*)

Name of Insured (*if different*)

- ☐ If you have X-Rays that are less than a year old at a previous dental office, please ask for the Dental Records Release Form.

EMAIL RELEASE FORM

I _____, give permission to Dr. Morley's dental office to communicate with me via email
(*Patient Name*)

regarding matters related to my health and dental treatment. I understand that it is not the policy of the practice to encrypt any information sent via email, and therefore the information is not secure. I acknowledge and accept the risk associated with corresponding confidential information through email. I will not hold the practice or any of its staff liable for any loss of confidentiality associated with information that is transmitted through email.

Patient Email Address

Patient Signature (*or Representative, detail relationship*)

Date

CONFIDENTIAL 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 impact on your dental treatment. Thank you for answering the following questions.

Do you take any medications,
pills, or drugs?

☐ Yes ☐ No If Yes, please list below (or provide a detailed list)

Do you or have you had in the last 6 months any of the following?

- | | | |
|---|---|--|
| ☐ Allergies | ☐ Head Injuries | ☐ Rheumatism |
| ☐ Alzheimers / Dementia | ☐ Heart Disease | ☐ Radiation Treatment |
| ☐ Arthritis | ☐ Heart Attack | ☐ Respiratory Problems |
| ☐ Artificial Joint
___/___/___ | ___/___/___ | ☐ Rheumatic Fever |
| ☐ Asthma | ☐ Heart Murmur | ☐ Seizure Disorder |
| ☐ Anemia | ☐ Heart Stent | ☐ Sinus Problems |
| ☐ Atrial fibrillation | ☐ Heart Valve Replacement | ☐ Shingles |
| ☐ Blood Disease | ___/___/___ | ☐ Stomach Problems |
| ☐ Cancer | ☐ Hepatitis | ☐ Stroke |
| ☐ Cold Sores | ☐ High Blood Pressure | ___/___/___ |
| ☐ Diabetes | ☐ HIV/Aids | ☐ Tobacco Use - |
| ☐ Dizziness | ☐ Jaundice | Chew/Smoke |
| ☐ Endocarditis | ☐ Kidney Disease | ☐ Tuberculosis |
| ☐ Epilepsy | ☐ Liver Disease | ☐ Tumors |
| ☐ Excessive Bleeding | ☐ Mental Disorders | ☐ Ulcers |
| ☐ Fainting | ☐ Nervous Disorders | ☐ Venereal Disease |
| ☐ Glaucoma | ☐ Pacemaker | |
| | ☐ Pregnancy | ☐ Allergies to Medications |

Other/Notes: _____

If you could change anything about your mouth, teeth, or smile, what would it be?

I hereby certify that I have read and understand the preceding information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release my information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payors, and or healthcare practitioners. I authorize payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of any of my dependents.

Patient or Representative Signature

Date

CANCELLATION POLICY AGREEMENT

Every patient of this dental practice receives a unique reservation. When an appointment is made, time is reserved, materials are ordered, and arrangements are made so we can be ready for your specific treatment.

At least 24-hours advance notice is required to cancel or reschedule an appointment. This makes it possible for us to prepare a unique reservation for another patient who would be happy to fill your time slot. When no notice is given, it is extremely difficult for us to continue operations as needed.

There is a charge of __(\$55/hour)__ for missing scheduled appointments without notice. Repeated cancellations or missed appointments will result in loss of appointment privileges.

I _____ agree to comply with the policy described above.
Patient or Representative's Name

Signature of Patient (or Representative, detail relationship)

Date

Credit Card Reservation Form

The card information provided below will be charged on the day of your scheduled appointment if your appointment is not canceled within the requested 24-hours.

Credit Card #: _____

(Circle One): MC Visa Disc. Amex

Expiration Date: _____ CC Security Code: _____

Cardholder Name: _____

Cardholder Signature: _____ Date: _____

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing below, you grant permission to Dr. Morley's dental office to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment, and healthcare operations. Our Notice of Privacy Practices provides more details on our treatment, payments activities, and healthcare operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy policies at any time. If we should do so, we will issue a revised Notice. Since revisions may apply to your healthcare information, you have a right to receive a copy by contacting our office. You also have the right to revoke your consent by giving written notice to Dr. Morley's office. This revocation, however, will not affect actions that were already taken in reliance upon this consent form. You should understand that if you revoke this consent, we may decline to treat you.

You are entitled to a copy of this form after you sign it.

Signature of Patient or Patient's Representative

Date

Printed name of Patient's Representative and Relationship

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name

Signature of Patient / Guardian

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.