Lisa R. Burkett, DDS, MS

Please Print

DATE_____
NAME_____
NICKNAME_____ MALE FEMALE
ADDRESS_____
CITY_____STATE_____ZIP_____
HOME PHONE_____CELL PHONE_____
EMAIL_____
OCCUPATION_____.EMPLOYER_____
WORKPHONE_____AGE_____DOB_____SS#_____
MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
SPOUSE'S NAME or EMERGENCY CONTACT PERSON_____
PHONE.....RELATIONSHIP……
INSURED'S NAME (POLICYHOLDER)..... DATE OF BIRTH.....
ID.....GROUP # .....INSURANCE
COMPANY_____
ADDRESS_____CITY_____
STATE_____ZIP_____
EMPLOYER THAT PROVIDES INSURANCE_____
INSURED'S RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

How is the best way for us to reach you for appointment and health information.
Mobile Email Text Home Phone

WE ARE NOT A PROVIDER FOR ANY INSURANCE COMPANY, PATIENT IS RESPONSIBLE FOR PAYMENT FOR ALL SERVICES. INSURANCE CLAIMS WILL BE FILED FOR PATIENT FOR REIMBURSEMENT FOR ALL TREATMENT
_____INITIAL PLEASE_____DATE

H E A LT H H I S T O RY
For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out areas which pertain to you. All information is private and confidential.
DENTIST..... CITY.....HOW LONG.....
DATE OF LAST VISIT..... LASTCLEANING.....LAST X-RAYS.....
DO YOU WANT TO KEEP YOUR TEETH? YES OR NO / OR DO YOU WANT OPTIONS? YES OR NO

CHECK ANY OF THE FOLLOWING

DO YOU HAVE MOUTH DISCOMFORT Y N PREVIOUS PROSTHODONTIC TREATMENT Y N
GRIND OR CLENCH YOUR TEETH Y N ORTHODONTIC TREATMENT Y N
SENSITIVE TEETH HOT, COLD, SWEETS Y N FEAR OF DENTAL TREATMENT Y N

TO WHOM DO YOU WANT TO GIVE PERMISSION TO SPEAK ABOUT APPOINTMENTS and TREATMENT?

NAME_____RELATION SHIP_____

DO YOU HAVE A POWER OF ATTONERY YES / NO

NAME OF GUARDIAN_____

PLEASE PROVIDE A COPY TO PROCEED WITH TREATMENT

MEDICAL HEALTH how would you describe your present health? EXCELLENT GOOD FAIR POOR

List your current physician(s)

_____ Type_____How Long?_____

_____ Type_____How Long?_____

Date of last physical Exam_____
Purpose_____
Findings _____
Height_____ weight_____

Are you aware of any changes in your general health in the last year? No Yes
Have you been hospitalized for illness or surgery in the past two years? No Yes
Have you been under a medical doctor's care during the past two years? No Yes
Have you ever had excessive bleeding that required special treatment? No Yes
Is there any history of diabetes in your family? No Yes
Are you required to restrict your work activity in any way? No Yes
Are you on a special or restricted diet of any kind? No Yes
Do you smoke or use tobacco products (CHEW / DIP)? No Yes

HOW MUCH?..... HOW LONG?.....

LIST ALL MEDICATIONS AND WHY YOU'RE TAKING THEM (include all over the counter). For example: "Lipitor, for cholesterol. **IF YOU HAVE A LIST, PLEASE PROVIDE IT TO THE FRONT DESK**

PLEASE CIRCLE OR CHECK ANY CONDITION YOU HAVE

Cancers or Tumors.	Radiation Treatment	Chemotherapy
Osteoporosis	Arthritis/rheumatism	Glaucoma
Liver Disease	Hepatitis – A B C	Ulcers
Jaundice	AIDS	Blood Transfusion
Drug or Alcohol Addiction	Venereal Disease	Anxiety/nerves
Psychiatric Care	Artificial Joint (Knee, Hip, Shoulder)	
Kidney/Bladder Trouble	Thyroid Disease	Emphysema.
Persistent cough	Tuberculosis	Asthma.
Sinus Problems	Allergies or Hives	Diabetes
Frequent Thirst	Frequent Urination	Stroke
Epilepsy	Seizures	Frequent Headaches.
Fainting or Dizzy spells	Weight Gain	Weight Loss
Heart Trouble	Heart disease or attack	Angina
High Blood Pressure	Low Blood Pressure	Heart Murmur
Rheumatic Fever	Congenital Heart Lesions	Artificial Heart Valve
Scarlet Fever	Heart Pacemaker	Heart Surgery
Anemia	Sickle cell disease	Swelling of ankles

ANY CONDITIONS NOT LISTED_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM DR. BURKETT ON OR BEFORE MY NEXT APPOINTMENT.

PATIENT'S SIGNATURE_____DATE _____

DOCTOR'S SIGNATURE_____ DATE_____

Consent for Services

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all treatment services.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that

I authorize the dentist to release any 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 for my insurance claim to be submitted electronically. I consent and agree.

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I my have made in the completion of this form.

PATIENT SIGNATURE_____DATE_____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my dental care, Dr. Lisa R. Burkett maintains health and dental records describing my health and dental history,

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Lisa R. Burkett reserves the right to change the use of my health/dental information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare/dental operations and that the organization is not required to agree to the restrictions requested.

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.**

I have read the above Acknowledgement of Receipt of Notice of Privacy Practices. If you would like a copy please make a request and our front desk will give this copy. If a patient refuses to sign, it does not prevent a health care provider from using or disclosing information in ways already permitted under HIPAA.

PATIENT'S SIGNATURE FOR ACKNOWLEDGMENT_____DATE _____

PATIENT'S SIGNATURE TO DENY ACKNOWLDEGEMENT _____ DATE_____