Echo Family Dental
JOHN D. GILLARD, DDS
CHELSI K. SCHUMACHER, DDS

ACQUAINTANCE FORM

Name _____Birthdate_____

Address_____Phone_____

City_____ State_____ Zip_____ Driver's License_____

SS#_____ Email Address_____

Employer_____ Work #_____Ext_____

Spouse's Name_____Birthdate_____SS#_____

Employer_____ Work #_____Ext_____

Person responsible for statement_____ Home phone_____

Address (if different from above) _____

Referred by_____

Closest Relative not living with you_____Address_____Phone_____

Insurance Information

Do you have double coverage? Yes_____ No_____

Your Insurance Company
Insurance Co._____
Address_____
City_____ State_____ Zip_____
Phone#_____
Badge#_____ Group#_____
Union & Local#_____
Social Security#_____
Date of Birth_____

Spouse's Insurance Company
Insurance Co._____
Address _____
City_____ State____ Zip_____
Phone#_____
Badge#_____ Group#_____
Union & Local#_____
Social Security#_____
Date of Birth_____

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION. (for patients 18 years or older)

Name: _____D.O.B: _____/_____/_____

_____ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This "Release of Information" will remain in effect until terminated by me in writing. This information may be released to:

_____ Spouse _____ Child(ren) _____
_____ Parent(s)_____ Other _____

_____ Information is not to be released to anyone.

Signature: _____ Date: _____

HEALTH HISTORY: Patient's Name: _____

If your list of medications or allergies is large please attach a copy to the health history form.
Name and Phone Number of your MEDICAL Doctor or Clinic

Do you have any allergies, if so please list them? (Sulfa Drugs, Sedatives, Iodine, Aspirin, Antibiotics, Etc.)_____
_____
_____

Please list all medications, supplements and over the counter medications you are presently taking_____
_____
_____
_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?

Yes_____ NO_____

Indicate which of the following you have had or have at present. Check all that apply.

____Pre-Med-Clind	____Pre-Med-Other	____Pre-Med-Amox	____Abnormal Bleeding
____Allergy-Aspirin	____Allergy-Codeine	____Allergy-Latex	____Allergy-Other
____Allergy-Penicillin	____Allergy-Sulfa	____Allergy Dental Anest	____Allergy-Erythromycin
____Anemia	____Arthritis/Rheumatism	____Artificial Heart Valve	____Artificial Joints
____Asthma	____Bisphosphonates	____Blood Disease	____Blood Thinner
____Blood Transfusion	____Cancer	____Chemo/Radiation	____Cholesterol
____Colitis	____Diabetes	____Drug Abuse	____Emphysema
____Epilepsy	____Excessive bleeding	____Glaucoma	____Head Injuries
____Heart Attack	____Heart Defects	____Heart Disease	____Heart Murmur
____Heart Surgery	____Hemophilia	____Hepatitis A, B, or C	____High Blood Pressure
____HIV/AIDS	____Jaundice	____Kidney Disease	____Liver Disease
____Low Blood Pressure	____Mental Disorders	____Nervous Disorders	____Osteoporosis
____Other	____Pacemaker	____Persistent Cough	____Pregnancy
____Respiratory Problem	____Rheumatic Fever	____Seizures	____ Sinus Problems
____Stomach Problems	____Stroke	____ Thyroid Problem	____ Tobacco Use
____Transplant	____Tuberculosis	____Tumors	____Ulcers

Are you under a doctor's care for any other medical conditions not listed above? Have you been a patient in the hospital in the past year?

FOR FEMALES ONLY
Are you pregnant? If yes, when is your due date?

HIPAA and Consent Form

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign to ECHO FAMILY DENTAL all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

CONSENT FOR SERVICES

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

As a condition of treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. A service of 18% annual on the unpaid balance will be charged on all accounts exceeding 90 days. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

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, or within five (5) days of billing if credit is extended. I further agree that the charges for service shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 and reasonable attorney fees if suit be instituted hereunder. I have read the above conditions of treatment and payment and agree to their content. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

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 operation, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. You may obtain a copy of our Notice of privacy Practices, including any revisions of our Notice, at any time by contacting: Chelsi Schumacher D.D.S 320-587-2769

Address P.O. Box 217 Hutchinson, MN. 55350

We reserve the right change our privacy practice 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.

I have had full opportunity to read and consider the contents of the Consent form and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent from, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____**Date**_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.