Welcome to the office of Dr. Heather Bobb. You have chosen an exceptional dental provider and team committed to providing you with personal and quality care. We are excited about having you join our family. Thank you!

We work with many insurance companies and as a courtesy to you we will bill your insurance. Insurance benefits change regularly making it impossible to guarantee quotes. However, we can often give you an ESTIMATE for services. Payment is required to secure your next appointment.

PATIENT INFORMATION

Full Name________________________________ Date of Birth ______________ M/F

Home Address____________________________ City ______________________________

State __________ Zip Code ______________ Email ______________________________

Home Phone __________________________ Mobile Phone ___________________________

Marital Status O S O M O W O D SS#________________________________

Emergency Contact ______________________________ Phone # _______________________

Who may we thank for referring you to our office? ___________________________________

If you would like us to file your insurance claim for you please complete the following:

DENTAL INSURANCE__________________ INSURANCE PHONE__________________

NAME OF SUBSCRIBER_________________________ DATE OF BIRTH______________

SS#________-_________-________ MEMBER NUMBER_________________________

GROUP NUMBER __________________ EFFECTIVE DATE ______________________

RELATIONSHIP TO PATIENT ________________ EMPLOYER ____________________

I authorize my insurance benefits be paid directly to Dr. Heather Bobb otherwise payable to me. I also authorize Dr. Heather Bobb to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I understand that I am responsible for payment of all dental services on the date of service, if not before. By providing my signature I authorize Dr. Heather Bobb to administer medications and perform diagnostic and therapeutic procedures that may be necessary for my dental care.

Patient or Guardian Signature

Signature____________________________________ ***Date***______________________

Printed Name_________________________________

PATIENT NAME ________________________________

Health Information

Are you currently under a physician's care?_____ Phys. Name and Phone ________________________

Do you use tobacco? ____ If yes, how long ___ Have you ever been hospitalized/major surgery? ______

List medications ____

Please circle any allergies to: *Latex* *Metal* *Aspirin* *Penicillin* *Codeine*

Please list any other allergies: ____

Please circle if you have any of the following:

Artificial Heart Valve	Kidney Stones/Problems	Abnormal Bleeding	Shingles
Heart Disease	Frequent Urination	Anemia	AIDS / HIV
Heart Murmur	Blood in urine	Bruise Easily	Cataracts
Heart Attack/Heart Surgery	Prostate Problems	Blood Diseases	Glaucoma
High Blood Pressure	Osteoarthritis	Blood Transfusion	Anxiety
Pacemaker	Rheumatoid Arthritis	Hemophilia	Depression
Swollen Ankles	Artificial Joints	Sickle Cell Disease	Bipolar Disorder
Asthma/Breathing Problems	Chronic Pain	Seasonal Allergies	Schizophrenia
Chronic Cough	Diabetes	Sinus Problems	Psychiatric Care
Emphysema	Thyroid Disorders	Cancer	Cold Sores
Tuberculosis	Seizures	Chemotherapy	Fever Blisters
Liver Problems	Dizzy Spells	Radiation Therapy	Lesions in Mouth
Ulcers	Headaches/Migraines	Autoimmune Disorder	
Reflux/GERD	Stroke	Hepatitis	

As the patient, I understand and agree with all of the above information and I have informed the dentist of any and all pertinent medical history.

INITIALS______________

HEATHER H. BOBB
DDS

DENTAL HISTORY:

What was the reason of your last dental visit?__________________

What was the date of your last dental visit?____________________

How often do you brush_____________________ floss_____________________ ?

Are any of your teeth sensitive to (please circle): **Hot** **Cold** **Sweets** **Chewing**

Do you get food caught in your teeth or gums? Yes No

Have you noticed any changes in your bite? Yes No

If yes, please explain____

Do you notice a pop in your jaw? Yes No

Do you have difficulty opening or closing your mouth? Yes No

Have you ever had any of the following?

Gum disease Yes No

Worn a nightguard/bite plate/retainer Yes No

Orthodontics Yes No

Have you ever had an upsetting dental experience? Yes No

If yes, please explain____

____

Is there anything you would change about your smile? Yes No

If yes, please explain____

____

____

Printed Name: ______________________________

HEATHER H. BOBB DDS

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of you **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this __________ date of _________, 20____.

Print patient name: ________________________________

Relationship to patient: ______________________________

Signature: ____

I give the office of Heather Bobb, DDS permission to share my protected health information with the following people:

Name ______________________________ Relationship ___________________________

Name ______________________________ Relationship ___________________________

Name ______________________________ Relationship ___________________________