USD Delta Dental Oral Health Center

(605) 658-5959
(605) 658-6087

101 Center For Health Education, 414 E Clark Street
Vermillion, South Dakota
570699986
USA
DH@USD.EDU

Patient Information Request Form*

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First name - Patient

Middle name

Last name - Patient

Patient date of birth

Gender

Email address

Contact Information

Home #

Work #

Mobile #

Patient mailing address

Patient billing address

Emergency Contact Information

Emergency #

Emergency contact

Family doctor

☐ Has the main contact for the family, (usually a parent or guardian) changed since your last visit?

Family doctor #

☐ Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?

Dental Insurance Information

- [ ] Insurance Company Name

- [ ] Insurance address

Policy Holder Information

- [ ] Self
- [ ] Spouse
- [ ] Parent/Guardian

- [ ] Policy Holder First and Last Name
- [ ] Policy Holder DOB (mm/dd/yyyy)

Employer

- [ ] Member ID
- [ ] Group ID

- [ ] Policy Holder Address

Other Information

Occupation

- [ ] Has your insurance information changed since your last visit?

Preferred pharmacy

Pharmacy #

Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices: 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 operations, of the uses and disclosures 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 reserve the right to change our privacy practices 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.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Delta Dental Oral Health Center USD Dental Hygiene
101 Center for Health Education
414 East Clark St
Vermillion, SD 57059
605-658-5959
or dh@usd.edu

or
USD Sioux Falls Dental Clinic
521 N. Main Ave
Suite 202
Sioux Falls, SD 57104
or dhsf@usd.edu

I acknowledge I was given opportunity to read a copy of this office’s Notice of Privacy Practices and offered a hard copy, if so requested.

☐ Accept

☐ Decline

Consent for Use and Disclosure of Protected Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

☐ I Consent

Patient Information Request Form*

☐ I Revoke

Education and Research

I release my electronic health record to be used for educational and research purposes.

☐ Yes

☐ No

Consent for Treatment and Release

Read Carefully:
I authorize the performance upon myself or my dependent any necessary dental procedure of a diagnostic, preventive, operative, surgical, or prosthetic nature. The nature and purposes of the treatment and the risks involved and the possibility of complications will be fully explained to me by the Dentist Supervisor, faculty, or the student. I will be given the opportunity to preview any treatment plan or plans designed for my case and choose or reject the same. Such procedures will be under the direction of the Dentist Supervisor.
1. I understand that the Department of Dental Hygiene at the University of South Dakota is a teaching facility and that with exception of continuing education courses, visiting dentists or dental hygienists, dental hygiene faculty, or the Dentist Supervisor, the work will be performed by student dental hygienists and checked by faculty. Services performed by students in the dental hygiene clinic are mandatory for professional preparation. Students under the direct supervision of licensed faculty members perform all services normally require more time to complete work than licensed dentists or dental hygienists.
2. I consent to the performance of services indicated to me and to such additional procedures different from those now contemplated, whether or not arising from presently unforeseen conditions, which the Dentist Supervisor in charge may consider necessary or advisable in the course of treatment.
3. I consent to the administration of such anesthetics, drugs, or chemical, as may be considered necessary or advisable by the Dentist Supervisor.
4. For the purpose of advancing dental education, I consent to the admittance of observers to the operatory.
5. I release, for professional use only, all records, radiographs, tapes, photographs, or videotapes made as a record of my treatment.
6. I agree to pay for all services rendered me on the day they are performed or completed.
7. No guarantees or assurances have been given by anyone as to the result that may be attained.
8. I attest that the information I provided regarding my medical and dental history is complete, accurate, and true.
9. I agree that I have read and understand the USD Dental Hygiene Patient Rights and Care Policies.
10. I understand that the procedures performed on me at the USD Dental Hygiene campus clinic do not include nor can be substituted for a complete dental exam. I understand that a complete evaluation and subsequent care must be accomplished with my dentist and others to whom this clinic and/or my dentist refers me.

In consideration of allowing treatment, I agree to hold harmless, release, and indemnify agents, servants, and students of the University of South Dakota and employees including, but not limited to dentists, and dental hygiene faculty, from any and all causes of action, claims, demands, or liability which may arise out of such treatment on behalf of myself, my heirs, my executors, administrators or assigns; or on behalf of my minor child or children or his/her (their) heirs, executors, administrators or assigns.

Patient signature: ________________________________ Date:__________________