HEALTH HISTORY

Mr. Mrs. Ms. Dr. Home Phone# Cell Phone#
ADDRESS Date of Birth
City State Zip Height Weight
Occupation E-mail SSN
Business Name and Address Work Phone #
Emergency Contact Name Phone #
Pharmacy Name and Location
Who referred you to our office/who is your general dentist?

DENTAL INFORMATION (Please place an 'X' where it applies.)

YES	NO	UNKNOWN	
○	○	○	Do you currently have any pain or sensitivity?
			If yes, explain:
○	○	○	Has a physician ever recommended antibiotics prior to dental treatment (pre-med)?
○	○	○	Do you currently take antibiotics (pre-med) prior to dental treatment?
			If yes, what antibiotic do you take?
○	○	○	Have you had a serious/difficult problem with dental treatment?
			If yes, explain:

MEDICAL INFORMATION

Primary Physician: Phone #
Please list any specialists:

YES	NO	UNKNOWN	
○	○	○	Do you feel healthy today?
○	○	○	Are you in good health?
○	○	○	Has there been any change in your general health within the past year?
○	○	○	Do you smoke? If yes, how many years have you smoked?

How much do you smoke daily?

Do you have any of the following diseases or problems?

○	○	○	Active Tuberculosis
○	○	○	Persistent cough
○	○	○	Fever, malaise, or weight change within the last 2 weeks?
○	○	○	Serious illness, operation/surgery, or hospitalization within the last 5 years?
			If yes, explain:
○	○	○	Artificial joint replacement
○	○	○	History of heart surgery
○	○	○	Autoimmune Disorders
○	○	○	Osteoporosis and/or Bisphosphonate use
○	○	○	Diabetes: ☐ Type 1 ☐ Type 2 If yes, most recent A1C and date of test?
○	○	○	Are you alcohol and/or drug dependent?
○	○	○	Do you use drugs or other substances for recreational purposes?

Please list any medications (and dosages) you are taking, including any herbal remedies, vitamins, and supplements:

Allergies: Are you allergic to, or have you had a reaction to:

YES	NO		YES	NO	
○	○	Local Anesthetics	○	○	Latex, Band-aids, Rubber
○	○	Aspirin	○	○	Barbiturates, Sedatives
○	○	Penicillin	○	○	Sulfa Drugs
○	○	Codeine or narcotics	○	○	Food

Other (please specify)

If yes to any allergy, please specify type of reaction:

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MEDICAL INFORMATION CONTINUED
(Please place an 'X' where it applies, even if condition is controlled with medication.)

YES	NO	UNKNOWN		YES	NO	UNKNOWN	
○	○	○	Abnormal Bleeding	○	○	○	Heart Attack
○	○	○	AIDS or HIV Infection	○	○	○	Heart Murmur
○	○	○	Anemia	○	○	○	High Blood Pressure
○	○	○	Angina	○	○	○	High Cholesterol
○	○	○	Arthritis	○	○	○	Hip Replacement
○	○	○	Artificial Heart Valves	○	○	○	Kidney Problems
○	○	○	Asthma	○	○	○	Knee Replacement
○	○	○	Cancer/Chemotherapy/Radiation	○	○	○	Mental Health Disorders
○	○	○	Chest pains upon exertion	○	○	○	Mitral Valve Prolapse
○	○	○	Chronic Pain	○	○	○	Pacemaker
○	○	○	Claustrophobic	○	○	○	Persistent Diarrhea
○	○	○	Diabetes ☐ Type 1 ☐ Type 2	○	○	○	Recurrent Infections
○	○	○	Immunosuppression (Drug, disease, or radio induced)	○	○	○	Respiratory Problems
				○	○	○	Rheumatic Heart Disease
○	○	○	Epilepsy	○	○	○	Sinus Trouble
○	○	○	Esophageal Reflux	○	○	○	Stroke
○	○	○	Excessive urination	○	○	○	Thyroid Problems
○	○	○	Fainting Spells/Seizures	○	○	○	Ulcers/Heartburn
○	○	○	Glaucoma				

Do you have any disease, condition, or problem not listed above? If so, please explain:

(Women Only)

YES	NO	UNKNOWN	
○	○	○	Are you pregnant?
○	○	○	Taking birth control pills? (Antibiotics may inactivate birth control pills.)
○	○	○	Are you nursing?

Both the doctor and patient are encouraged to discuss any other relevant patient issues prior to treatment. I consent to have necessary examination and x-rays completed. I acknowledge that I am responsible for fees for services rendered. I understand that it is my obligation to return for advised follow up appointments. I understand that if there are any post-operative problems or misunderstandings, it is my obligation to return.

I certify that I have read and understand the above. I certify that I have answered all questions truthfully to the best of my knowledge. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Signature of Dentist Date

Health History Update: The patient should review this document to update any changes yearly. A new form should be completed every two years.

_____ _____ _____
Date of Update Signature of Patient Signature of Dentist

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____