Medical History Form

Date: _____

Patient Information

Patients Name _____
LAST FIRST MIDDLE INITIAL

Social Security # _____ Sex: M/ F Date of Birth: _____ Age: _____

Responsible Party (Parent or Guardian Information)

Last Name _____ First _____ M.I. _____Marital Status _____

Address _____City _____ State _____Zip Code _____

Driver's License No. _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____

Emergency Contact: Name/ Address/ Phone #. _____

How did you hear about our office?

_____

Reason for today's visit _____

Date of last dental visit _____ Reason _____

Have you ever had an experience in a dental office that you would like to tell us about? YES NO

If yes, please explain:

_____

Do your gums bleed, feel tender or irritated? YES NO

Are your teeth sensitive to hot, cold, sweets, pressure? YES NO

Are you interested in braces? YES NO

Name and Phone # of my Physician(s) is _____

List all medications the patient is currently taking: _____

Are you or think you may be pregnant? YES NO If YES, how long? _____

Mark any of the following medical conditions that you may have or have had in the past:

☐ HIV+	☐ Diabetes	☐ Bruise Easily	☐ Heart Disease	☐ Pain in Jaw Joints
☐ Ulcers	☐ Glaucoma	☐ Scarlet Fever	☐ Thyroid Disease	☐ Venereal Disease
☐ Anemia	☐ Hay Fever	☐ Rheumatism	☐ Kidney Trouble	☐ Sickle Cell Disease
☐ Asthma	☐ Hemophilia	☐ Blood Disease	☐ Rheumatic Fever	☐ Cortisone Medicine
☐ Arthritis	☐ Emphysema	☐ Tuberculosis	☐ Chemo (Cancer)	☐ Epilepsy or Seizures
☐ Hepatitis	☐ Nervousness	☐ Heart Murmur	☐ Heart Pacemaker	☐ High/Low Blood Pressure

Mark any of the following medications you are allergic to:

☐ Local Anesthetics	☐ Penicillin or other antibiotic	☐ Barbiturates, sedatives or sleeping pills
☐ Sulfa Drugs	☐ Latex Allergies	☐ Codeine or other narcotics
☐ Other_____		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if any medicines change I will inform my dentist at the next appointment _____
Signature of Patient/Parent/Guardian

Doctor Signature Date

HIPAA CONSENT

Patient's Name: _____

Date of Birth: _____

☐ 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 and 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 your 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. In 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 healthcare operations, but that you are not required to agree to these requested restrictions. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: _____ Date: _____

OFFICE POLICIES

In an effort to avoid misunderstandings and to keep billing costs a minimum, we are presenting you with a statement of our policies concerning payment of your account and the processing of your insurance forms.

INSURANCE

This office is happy to cooperate with the patients who are covered by insurance. Please read your policy to be sure that you are fully aware of any limitations of benefits provided. It is important to understand that, in most cases, insurances are designed to reduce your costs, not eliminate completely. At the time of service, you will be asked to pay your percentage for routine dental work. You are ultimately responsible for the full amount of your bill, regardless of insurance coverage, as we are not a party to your insurance contract.

APPOINTMENTS

We will be as flexible as possible to meet your needs in scheduling appointments. Please give us **24hours notice** if you plan to cancel an appointment. Please honor your appointments!

FINANCIAL ARRANGEMENTS

Payment is expected at the time of treatment. This office accepts Visa, Mastercard, or cash. If an account is turned over for collection, a fee will be applied, plus interest and attorney fees.

I have read the above policy and agree to accept financial responsibility for my bills as outlined in the policy. I authorize the release of any information required to submit my dental claim(s).

Signature:_____ Date:_____