Health History

Physician's Name_____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____

WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

CHERISHED SMILES
FAMILY DENTISTRY

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

_____

Please Print (Last Name) (First Name) (MI)

Do we have your permission to:

1. Send a dental appointment postcard to your home? Y_____ N_____

2. Leave appointment, billing or dental information on your answering machine, voice mail or email? Y_____ N_____

I give permission to share my appointment, billing or dental information with the following individual(s):

_____

_____ _____

Signature of patient/parent/legal guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

_____ _____

Signature of patient/parent/legal guardian Date

FINANCIAL POLICY FOR CHERISHED SMILES FAMILY DENTISTY, PC

This form explains to all of our patients the billing process of the office.

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. We ask that all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you a rough estimate of your investment in your dental health, for each upcoming visit, based on your insurance plan. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility. Insurance balances are ultimately the patient's obligation.

Your dental appointments are scheduled carefully. We request 24 hours advanced notice for rescheduling your appointment. Failing to adhere to the 24 hour cancellation fee, may result in a broken appointment fee of $50.00.

A returned check fee of $35.00 will be added to your account for any returned check. Before we accept another payment by check, the $35.00 fee plus full payment for the check, that did not clear must be paid in cash or credit card.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement.

Delinquent balances over 90 days old will be referred to a collection agency and marked "inactive". In order to have your account "reactivated", and continue to receive dental treatment in our office, the delinquent balance plus a "reactivation fee" of 50% of the delinquent balance referred to the collection agency will be charged to your account. Only after this total account balance has been paid in full, can appointments be made and your account and patient status be reactivated

_____ _____

Signature of Patient or Guardian Date

_____ _____

Print name Witnessed by

CHERISHED SMILES
FAMILY DENTISTRY

Required language from the Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

The Health Insurance Portability and Accountability Act of 1996 requires that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers must also provide patients with a written Notice of Privacy Practices. This Notice is dated April 14, 2003. The Privacy Practices described will be in effect after this date and until or if they are replaced. Our office Privacy Practices may change from time to time. If changes are made, a new Notice of Privacy Practices will be displayed in our office and provided to patients. You may obtain additional copies of this Notice on request. Additional information may be obtained from the Contact Officer listed on this brochure.

Uses and Disclosure of Information

(from Department of Health and Human Services, Standards for Privacy of Individually Identifiable Health Information, Parts 160-164) The following describes how information about you may be used.

Treatment Services

We may use or provide your health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointment reminders, recommendations of treatment alternatives, information about other health services and/or other office services.

Payment and Operations

We may provide your health information as required to allow for payment for services and participation in quality assurance, disease management, training, licensing, and certification programs.

Marketing

We will not use your health information for marketing purposes without your written consent.

Legal Requirements

We may disclose your health information when required to by law.

Threat to Health and Safety

If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

National Security

When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.

Family Members, Friends, and Others Involved in Care

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, care-giver, or personal representative of your location, condition, or death.

Patient Rights

You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing addressed to the contact officer listed on this brochure. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if copies are requested to be mailed. A summary of your health information can also be requested for a fee. Details of all costs are available from the contact officer.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last six years, but not before April 14, 2003. You may be charged for costs associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in case of an emergency).

If you believe that changes should be made to your health information, you must request this in writing. You must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified location you must make your request in writing.

Patient Authorizations

You may give us your written authorization to use or disclose your health information to anyone for any purpose. This authorization may be revoked, in writing, at any time. Without your written authorization, disclosures about your health information are limited to those listed in this Notice.

Questions and Complaints

If you have a complaint or need more information about our privacy practices please let us know. Your complaint may be related to a perceived violation of your privacy rights, access to your health information, requested changes in your records, or for any other reason. If you want to submit a written complaint to the U.S. Department of Health and Human Services we can provide you with the address. We completely support your right to privacy and will not retaliate should you decide to lodge a complaint.

Contact Officer_____

Telephone _____ FAX_____

E-mail _____

Address _____

_____

_____

For reorders call: 800-548-2164.
Item #BROC-PRIV1

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The United States Department of Health and Human Services, effective August 9, 2002, issued comprehensive federal regulations providing for protection of private medical information with which our office must comply. The final regulation, which goes into effect in April, 2003, is designed to protect patient's identifiable health information. These protections are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (If more stringent state laws exist, these must be observed).

The HIPAA privacy rule states that after April 14, 2003, health providers must provide patients with a written Notice of Privacy Practices and make a good faith attempt to obtain a written acknowledgement of such. This information should be provided to patients prior to or at the time of the first delivery of health services, except in cases of emergency. However, if a written acknowledgement is not obtainable, the attempt by the provider to obtain it is sufficient to comply with the rule.

In addition, a Notice of Privacy Practices must be displayed prominently and available for patients to take home. If the Notice is modified in the future, the new version must be displayed and available, and thereafter provided to patients at the time of their first treatment.