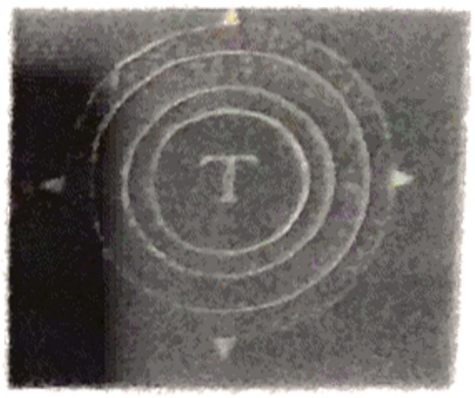

PATIENT INFORMATION AND HEALTH HISTORY

Patient Information

Last Name_____First Name _____ MI ____

Address _____
(Street) (City, State) (ZIP)

Home # (___)____-_____ Work # (___)____-_____ Cell # (___)____-____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Circle One: Single Married Divorced Widowed EMAIL: _____

Employer Name and Address _____
Job Title/Occupation_____ Date Started _____

Spouse Information

Last Name_____First Name _____ MI ____

Address _____
(Street) (City, State) (ZIP)

Home # (___)____-_____ Work # (___)____-_____ Cell # (___)____-____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Employer Name and Address _____
Job Title/Occupation_____ Date Started _____

Name of closest relative not living with you _____
Relative's Address _____
(Street) (City, State) (ZIP)
Relationship _____ Home Phone# (___)____-_____

Insurance Information

Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____ Group # _____
Secondary Insurance Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____ Group # _____

Additional Information

How did you find out about our office? _____
What is the reason for your visit with us today? _____
Are you under the care of a physician at this time? If so, what are you being treated for?_____
_____ Name of Treating Physician _____
Have you ever been required to pre-medicate with an antibiotic prior to dental work? Y ____ N ____
Have you been hospitalized within the past year? Y ____ N ____
If so, what for? _____
Do you use tobacco products? Y ____ N ____ If so, what kind? _____ How often? _____
Women Only…Are you or could you be pregnant? Y ____ N ____ If so, when is your due date? _____

Dental History

When was your last visit to a dental office? _____ What was done? _____

Have you even been diagnosed with Periodontal Disease? Y____ N____ Treatment Completed? Y____ N____

Do your gums bleed? Y____ N____

Is there anything about yourself that you think we should know? _____

Medical Information

Please check any of the following, which you have had or have at present.

_____ Abnormal Blood Pressure
_____ AIDS
_____ Allergies
_____ Anemia
_____ Angina
_____ Arthritis
_____ Artificial Heart Valve
_____ Artificial Joint(s)
_____ Asthma
_____ Blood Disorders
_____ Blood Pressure (HIGH)
_____ Blood Pressure (LOW)
_____ Blood Transfusion
_____ Bruise Easily
_____ Cancer
_____ Chemotherapy
_____ Chronic Cough
_____ Cold Sores
_____ Congenital Heart Disease
_____ Congestive Heart Failure
_____ Cortisone Medication
_____ Cosmetic Surgery
_____ Diabetes
_____ Drug Dependency
_____ Epilepsy
_____ Fainting Spells
_____ Glaucoma
_____ Heart Disease/Attack
_____ Heart Murmur
_____ Heart Pacemaker
_____ Heart Surgery
_____ Hemophilia
_____ Hepatitis A (Infectious)
_____ Hepatitis B (Serum)
_____ Herpes
_____ HIV Positive
_____ Jaundice
_____ Kidney Problems
_____ Leukemia
_____ Liver Disease
_____ Meningitis
_____ Mitral Valve Prolapse
_____ Organ Transplant
_____ Polio
_____ Psychiatric Treatment
_____ Radiation Therapy
_____ Rheumatic Fever
_____ Rheumatism
_____ Scarlet Fever
_____ Seizures
_____ Sickle Cell Disease
_____ Sinus Trouble
_____ Stroke
_____ Thyroid Disease
_____ TMJ (Pain in Jaw Joints)
_____ Tuberculosis
_____ Ulcers
_____ X-ray/Radiation Treatment

Other (Please Indicate) _____

Are you currently taking any medication? Y____ N____ If so, please list: _____

_____

Are you allergic or have you reacted adversely to:

Local Anesthetics	Y____ N____	Other Antibiotics(Penicillin)	Y____ N____
Aspirin	Y____ N____	Please List _____	
Sulfa Drugs	Y____ N____	Metals or	Y____ N____
Codeine	Y____ N____	Latex	Y____ N____
Other Narcotics	Y____ N____	Other Allergies – Please List _____	

Please Read Carefully and Sign

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in any of this information, I will inform the office at the next appointment. I do hereby authorize any dental service or procedure the doctor may deem necessary, for the above named patient or myself. I also authorize the administration of those local anesthetics or pre-medications which may be deemed advisable. I will be responsible for any financial obligation for treatment for myself or for the above named patient.

_____ _____

Signature of Responsible Party Date

_____ _____

Relationship Staff Member Signature

HIPAA CONSENT FORM
From the office of:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed. financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones. email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

_____ Patient gives office permission to use any contact written on patient registration form.

Please check any that you DO NOT want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.

__Work Cell	__Work Phone	__ Work Email	__Work Fax	__ Mail to Work
__ Personal Cell	__ Home Phone	__ Home Email	__ Home Fax	__Mail to Home
__Emerg. Contact	__Interpreter Contact			
__ Any of the above				

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

_____ **Full access / Partial access** _____

_____ **Full access / Partial access** _____

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAÃ compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: _____ **Date** _____

Print Legal Guardian's Name: _____ **Date** _____

Signature of Patient or Legal Guardian: _____ **Date** _____

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature_____ **Printed Name**_____ **Date** _____

Witnessed Staff Signature_____ **Printed Name**_____ **Date** _____