

HEALTH HISTORY UPDATE

So that we may ensure we are looking after your needs, please review and complete the following questionnaire.

Name: _____ Date of Birth: _____

Preferred Name: _____

Title (Please circle): MR. MRS. MISS. MS. DR. SSN: _____

Family Status (Please circle): SINGLE MARRIED CHILD OTHER

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home/Work Phone: _____

Email Address: _____

Have you had any of the following? (Please check each box that applies)

- | | |
|---|--|
| <input type="checkbox"/> Heart Problems/Prosthetic Valve | <input type="checkbox"/> Allergy to Anesthetics |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergy to Penicillin |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Allergy to Medications |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Allergy to Latex |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia/Other Blood Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Previous Infective Endocarditis | <input type="checkbox"/> Hepatitis (A, B, C, D or E) |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Liver/Kidney Problems |
| <input type="checkbox"/> G.E. Reflux/Persistent Heartburn | <input type="checkbox"/> Cancer/Chemotherapy/Radiation Treatment |
| <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Anxiety/Mood Disorder |
| <input type="checkbox"/> Excessive Bruising/Bleeding | <input type="checkbox"/> Pregnancy - Current Due Date: _____ |
| <input type="checkbox"/> Ulcers (stomach) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sinus Trouble | |
| <input type="checkbox"/> Tumor History | |

Are you currently taking any drugs or medications? (If yes, please list below)

Name of your Primary Care Physician:

Address: _____

Phone: _____

Emergency Contact (please provide name/relationship/phone number): _____

Primary Dental Insurance

Name of Insurance: _____

Subscriber: _____ Subscriber DOB: _____

Subscriber's Employer: _____

Relationship to Subscriber (please circle one): SELF SPOUSE CHILD OTHER: _____

Subscriber ID: Group Number/ID: _____

Phone Number (should be listed on back of card): _____

Secondary Dental Insurance

Name of Insurance: _____

Subscriber: _____ Subscriber DOB: _____

Subscriber's Employer: _____

Relationship to Subscriber (please circle one): SELF SPOUSE CHILD OTHER: _____

Subscriber ID: Group Number/ID: _____

Phone Number (should be listed on back of card): _____

Consent for Treatment

- 1) I hereby authorize the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- 2) Upon such diagnosis, I authorize the dentist to perform all treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.
- 3) I agree to the use of anesthetics, sedatives, and all other medication as necessary. I fully understand that using an anesthetic agent embodies certain risk. I understand I can ask for a complete recital of any possible complications.
- 4) I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
- 5) I authorize that this date may be reviewed by team members of the dental practice.

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 disclose my health information to carry out: Treatment, Obtain payment (i.e. my insurance co), The day-to-day healthcare operations.

I have been informed 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 under HIPAA and the right to change the terms of this notice from time to time and I may contact you any time to obtain a copy.

****To ensure timely treatment to all patients we require a 48 hour (2 business days) notice of intent to cancel in advance.**

Patient's Signature: _____ Date: _____

Parent/Responsible Party Signature (if under 18 years of age): _____

Relationship to Patient: _____