DENTALHOUSE
COME AS PATIENTS, LEAVE AS FAMILY

NEW PATIENT HEALTH HISTORY FORM

PATIENT: [☐ Please check if patient is a minor.] *(PLEASE PRINT CLEARLY)*

Last Name _____ First Name _____ Middle Initial _____ Cell Phone _____ Home Phone _____

Street Address _____ City _____ State _____ Zip Code _____

Birth Date _____ Age _____ Employer / School _____ Occupation / Title _____ Work Phone / Extension _____

Driver License Number _____ Social Security Number _____ Email Address _____ Gender: ☐ M ☐ F

SPOUSE: ☐ **Male** ☐ **Female** ☐ **Other**

Last Name _____ First Name _____ Middle Initial _____ Cell Phone _____ Home Phone _____

Birth Date _____ Age _____ Employer / School _____ Occupation / Title _____ Work Phone / Extension _____

Driver License Number _____ Social Security Number _____ Email Address _____

If PATIENT IS A MINOR, INFORMATION OF RESPONSIBLE PARTY:

Last Name _____ First Name _____ Middle Initial _____ Best Contact Number _____ Birth Date _____

Relationship to Patient _____ Home Address _____

Driver License Number _____ Social Security Number _____ Occupation / Employer _____ Gender: ☐ M ☐ F

DENTAL INSURANCE:

Insurance Name _____ Address _____

Policy Holder's Name _____ Policy Holder's Social Sec # _____ Member Number _____ Group Number _____

EMERGENCY CONTACT INFORMATION:

Name _____ Address _____

Phone _____ Relationship _____

Is another member of your family a Dental House patient? ☐ Yes ☐ No

Name _____

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MEDICAL / DENTAL HISTORY:

Are you experiencing dental pain or discomfort? ..... YES NO

Are you in good general health? ..... YES NO

Do you smoke or use tobacco products? ..... YES NO

Women: Are you pregnant or suspect you might be? ..... YES NO

Has there been a change in your general health within the past year? ..... YES NO

Please explain: _____

Are you under the care of a physician? ..... YES NO

If so, what condition is being treated? _____

Physician's Name _____ Phone Number _____

Please check any of the following that apply:

- ☐ AIDS (AI)
- ☐ Alcoholism (AL)
- ☐ Anemia (AN)
- ☐ Angina (AG)
- ☐ Artificial Heart Valve (AV)
- ☐ Artificial Joints (AJ)
- ☐ Arthritis / Rheumatism (AR)
- ☐ Asthma (A)
- ☐ Birth Control (BC)
- ☐ Blood Pressure – High (BH)
- ☐ Blood Pressure – Low (BL)
- ☐ Blood Thinners (BT)
- ☐ Bruise Easily (BB)
- ☐ Cancer (CA)
- ☐ Chemotherapy / Radiation (CR)
- ☐ Congenital Heart Disease (CH)
- ☐ Deaf (DF)
- ☐ Diabetes (DB)
- ☐ Drug Dependency (DD)
- ☐ Eating Disorder (ED)
- ☐ Emphysema (EM)
- ☐ Epilepsy (EP)
- ☐ Fainting / Dizziness (FD)
- ☐ Fever Blisters / Cold Sores (FS)
- ☐ Gag Easily (GE)
- ☐ Glaucoma (GL)
- ☐ Headaches – Frequent (HF)
- ☐ Heart Attack (HA)
- ☐ Heart Murmur (HM)
- ☐ Hemophilia (HP)
- ☐ Hepatitis (H)
- ☐ Hereditary Dis. / Deformities (HD)
- ☐ HIV Positive (VP)
- ☐ Herpes (HR)
- ☐ Hives (HI)
- ☐ Hyper Activity (HY)
- ☐ Hypoglycemia (HG)
- ☐ Jaundice (JC)
- ☐ Kidney/Liver Disease (KL)
- ☐ Mitral Valve Prolapse (HV)
- ☐ Night Sweats (NS)
- ☐ Osteoporosis (OS)
- ☐ Paralysis (PL)
- ☐ Prolonged Bleeding (PB)
- ☐ Psychiatric Treatment (PT)
- ☐ Rheumatic Fever (RF)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sickle Cell Disease (SD)
- ☐ Sinus Trouble (ST)
- ☐ Stroke (SK)
- ☐ Tuberculosis (TB)
- ☐ Tumors (TM)

Have you had any other serious illness? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

_____

DRUGS / MEDICATIONS:

Are you allergic to or have you had a bad reaction to:

- ☐ Aspirin (AA)
- ☐ Barbiturates (AB)
- ☐ Codeine (AC)
- ☐ Erythromycin (AE)
- ☐ Iodine (AD)
- ☐ Keflex (AK)
- ☐ Local Anesthetic (LA)
- ☐ Nitrous Oxide (NO)
- ☐ Narcotics (NA)
- ☐ Penicillin (AP)
- ☐ Sulfa (AS)
- ☐ Tetracycline (AT)
- ☐ Latex
- ☐ Other Allergies: _____

_____

Have you taken any medication in the last six months? ☐ Yes ☐ No

Please list: _____

Please list any medication(s) you are taking now: _____

Reason(s): _____

_____

_____

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NEW PATIENT GENERAL CONSENT

GENERAL CONSENT

Thank you for choosing **Dental House** for your dental care!

We are eager to work with you to help you achieve excellent oral health! While we pledge to maintain strict standards of safety in your clinical care, dental treatment, like treatment of any part of your body, carries some inherent risk. Your clinician will always weigh the risks versus rewards and discuss them with you, however, no clinical procedure is 100% risk-free. Treatment decisions will be made between you and your dentist after discussing the potential outcomes of your treatment plan. These risks are seldom great enough to offset the benefits of treatment but they should be considered when making treatment decisions.

Benefits of dental treatment can include relief from pain, increased ability to chew, and all the psychological and social benefits of a brighter, more pleasing smile. Still, there are some risks that almost all dental procedures carry:

1. Drug or chemical allergic reactions
2. Long-term numbness
3. Muscle or joint tenderness
4. Sensitivity in teeth of gums, infection, bleeding
5. Swallowing/inhaling small objects

Your safety and comfort are important to us! While no health care treatment can be totally predictable, it goes without saying that we will utilize all our knowledge and experience to make sure your treatment plan's outcome is the one you want.

Please feel free to ask your doctor questions when they arise. We are here for you!

_____ _____

Patient (or Parent/Guardian) Signature Date

_____

Print Name

_____ _____ _____

Relationship to Patient Date Witness

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HIPAA/PRIVACY NOTICE RECEIPT AFFIRMATION

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member(s), friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will *not* use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provoke copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for x-ray copies and $0.25 for each copied page of your health information. Postage may be charged if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before February 14, 2017. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make this request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternate means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or via electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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HIPAA RECEIPT AFFIRMATION

AFFIRMATION

I affirm that I have received and read the Notice regarding my patient rights. I understand that if I want a copy of my patient rights, I may ask for it.

_____ _____

Patient (or Parent/Guardian) Signature Date

_____

Print Name

_____ _____

Relationship to Patient (if patient is a minor) Date

CANCELLATION POLICY

Dear Patients:

Our mission *truly* is to provide you with premium care at an affordable price. In order to keep providing this first-rate level of care and comfort, our office requires your participation or we cannot continue our current clinical model. That would be heartbreaking for us, as we know of no other way.

In this time, we are restricted in the number of patients we can see daily so each and every chair time is extremely important to the survival of our practice. Because of such difficult conditions, just **two** incidents of the following will unfortunately force our office to consider when or whether we can set another appointment:

- *Not showing up* for a chair time without any notice, or without two days prior notice
- *Canceling or rescheduling* a chair time less than two days prior

We do not double- or triple-book like some other offices. This means if you cancel or do not show without giving our office time to rebook your time slot, your chair remains empty. Two treatments can equal roughly a half-day or more, which can threaten the survival of our office. If you are feeling unwell, please let us know and we will not count it against you.

We hope you work with us in this difficult time so that we may continue providing the best dental experience in town. If we work together, like all things in life, everybody wins.

_____ _____

Patient/Guardian Signature Date

_____

Please Print Patient Name