PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | Today's Date: | Date of Last Visit: | Date of Med. History:

City State Zip: | Email:

Home Phone: | Work Phone: | Cell Phone: | Birth Date: | Social Security No.: | Marital Status:

Primary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Secondary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Physician Name: | Physician Phone:

Pharmacy: | Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP: Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Acid Reflux
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Anxiety/Depression
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Thinners
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS

Y N	Conditions
☐ ☐	Hay Fever
☐ ☐	Heart Arthymia
☐ ☐	Heart Attack
☐ ☐	Heart Murmur
☐ ☐	Heart Surgery
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	High Blood Pressure
☐ ☐	Joint Replacement
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Osteoporosis
☐ ☐	Pace Maker
☐ ☐	Premedicate
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stent
☐ ☐	Stomach Problems
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is available in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Print Name:_____

I, (Signature)_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Smileworks Dental Insurance Consent Agreement

Your Dental Care is Important. Your Insurance Benefits Greatly Help. This is how they work together.

1. Every insurance policy is different. We will help explain the benefits you have with your individual plan, but it is also up to you to investigate and learn exactly what benefits you have and what you don't have. We're happy to help you.

2. As a participating provider, we have agreed to accept **Ameritas, CSEA, GHI, Blue Cross, Blue Shield, Delta, Aetna PPO, Cigna PPO, 464, Connection Dental Group, Dentamax, United Concordia, Sunlife, Guardian, MetLife** and **Principal, Assurant, and many others.** You are responsible for the patient portion at the time of service. We will file the insurance claim on your behalf. Any remaining fees or any service not covered by your insurance plan is 100% your responsibility. All proposed treatment will be discussed with you in detail prior to treatment.

3. A pre-determination may be requested and submitted to the insurance company on your behalf for preliminary review of proposed treatment. This review can take anywhere from 6-8 weeks. This is only an **ESTIMATE**. It is only when the actual dental claim is submitted and reviewed that payment is determined.

4. Since we don't know what your insurance will pay, if they pay more than expected, we will reimburse you the difference within 30 days of receiving it. If they pay less than expected, we will send a statement for the remaining balance, which is payable on receipt.

5. Our office accepts all major credit cards, checks and cash. Financing is available through CareCredit with proper approval. Pre-payment is also accepted to build up a credit on your account for future services.

6. When coming in for a hygiene visit, depending upon your periodontal condition you may need a gross debridement followed by scaling and root planning rather than a simple cleaning. Some insurance companies have larger co-pays for these services and unfortunately we are unable to preauthorize the debridement visit.

I have read and understand the financial criteria for Smileworks Dental, and agree to the terms stated above.

Patient or Parent/Guardian
Printed Name _____ Date _____
Signature _____