Medical History

Last name_____ First name_____ M.I.____

Date__/__/____ Date of birth __/__/____ Sex M F

Please answer the following questions: your answers are confidential. Do you have now or have you ever had any of the following?

Yes	No	
O	O	Are you in good health?
O	O	Are you now under the care of a physician? If yes for what? _____ If so, what is the name of your physician? _____
O	O	Are you taking any medications including non prescription herbs and vitamins? If so, please list with dosages and frequency taken. _____ _____
O	O	Are you taking, or have you taken any drugs for osteoporosis?
O	O	Are you allergic to any medications? If so please list them. _____
O	O	Are you allergic to latex?
O	O	Do you have high blood pressure?
O	O	Damaged heart valves or artificial heart valves.
O	O	heart murmur, rheumatic heart disease, angina shortness of breath after mild exercise.
O	O	Heart attack. If so date. __/__/_____
O	O	Respiratory problems, emphysema, or asthma
O	O	Hepatitis if so what type and date type___ Date__/__/____
O	O	Other liver disease or Jaundice
O	O	Diabetes if so date of diagnosis __/__/____
O	O	Thyroid problems
O	O	Kidney disease
		Tuberculosis/ cough that produces blood
O	O	Epilepsy/neurological disorders/seizures
O	O	Stomach ulcers
O	O	Blood disorders
O	O	Abnormal bleeding

O O HIV or AIDS
O O Have you been pre medicated before dental treatment?
If so what for_____
O O Temporal mandibular joint pain, problems, or treatments.
O O Hip replacement If so date__/__/____
O O Knee replacement if so date__/__/____
O O Other joint replacement if so date__/__/____
O O Do you use tobacco? if so how much_____
O O Do you drink alcohol? if so how much_____
O O Do you use recreational drugs? if so what and how often
_____
O O Do you have a history of VRE (vancomycin resistant enterococci) or MRSA?
O O Have you had any treatment for tumors or growths?
If so where and when?_____
Are there any medical problems not noted above?
_____
_____
Please list any surgeries you have had and dates
_____
_____

Female patients only
O O Are you pregnant or is there a chance you may be?
O O Are you breastfeeding?

Emergency contact name and phone number
_____

I certify that i have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed_____ Date __/__/____

Thank you for choosing Roger Densley D.D.S. It is our pleasure to care for you!

Patient Information

(This information is necessary for our files and will be confidential)

Today's Date

Patient information

Patient's Name_____Patient's Birthday O male O female
first last mi

Legal guardian name_____Relationship_____

Residence Address_____For how long_____ O own O rent
street city state zip

Patient is O Married O Single O Divorced O Separated O Widowed O Minor Email_____

Social Security number_____Residence phone_____Cell phone_____

Employed by_____How long?_____Occupation_____

Business Address_____Business phone_____
street city state zip

Name of nearest relative not living with you _____Relationship_____

Address_____ Phone_____
Street city state zip

Spouse's Information

Spouse's Name_____Social Security number_____

Occupation_____

Employed by_____ Business phone_____

Business Address_____
street city state zip

Health care information

Physician's name_____Address_____
street city state zip

Former dentist_____ Address_____
street city state zip

Why are you changing dentists_____

Purpose of appointment_____

Whom may we thank for referring you_____

Insurance information

Person responsible for this account_____Relationship_____

address if different than above_____Phone_____
street city state zip

Cell phone_____state aid number_____credit card number_____ exp date

Name of insurance company_____

Insured person's name_____Birth date if different from above

Social security number_____

Relationship to patient_____Name of group_____Group number_____

Plan number_____Name of union_____Local_____

Secondary insurance company_____

Insured person's name_____Birth date if different from above

Social security number_____

Relationship to patient_____Name of group_____Group number_____

Plan number_____Name of union_____Local_____

Treatment permission

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance

I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor or his staff, I agree to pay, therefore, the the reasonable value of said services shall be billed unless objected to me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach, of any term ore condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees. I grant permission to you, or your assigns to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed_____ Date__/___/____

Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 04114103, 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 OF HEALTH INFORMATION

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 to you. Payment: We may use and disclose your health information to obtain payment for services we provide to 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, 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. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 provide 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 $0.50 for each page, $1.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

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. Please read and sign the following information regarding our office policy. If you have any questions feel free to ask at the time of your appointment. We are currently accepting and welcoming new patients! Our team has been selected for their caring, friendly attitudes, as well as their highly qualified skills. We understand the needs of our patients and take great pride in delivering exceptional dental care. We make every effort to keep your cost down while maintaining the highest level of expertise. We see all patients on an appointment basis, and ask that you call in advance .so that we may reserve the appropriate time for you. If you know that you will be unable to make your appointment we kindly ask that you call as soon as possible to cancel your· appointment. Any appointment canceled in less then twenty-four hours before the scheduled time, or missed without calling, will automatically be charged a $25.00 cancellation or failed appointment fee. We accept Visa, Master Card, and Discover; checks will be accepted with a valid identification.

I have read the above conditions of treatment and agree to their content:

Signature_____Date____/__/____