Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis			
Persistent cough greater than a 3 week duration			
Cough that produces blood			
Been exposed to anyone with tuberculosis			

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets or pressure?			
Does food or floss catch between your teeth?			
Is your mouth dry?			
Have you had any periodontal (gum) treatments?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Do you drink bottled or filtered water?			
If yes, how often? ~~Circle one:~~ DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?			

	Yes	No	DK
Do you have earaches or neck pains?			
Do you have any clicking, popping or discomfort in the jaw?			
Do you brux or grind your teeth?			
Do you have sores or ulcers in your mouth?			
Do you wear dentures or partials?			
Do you participate in active recreational activities?			
Have you ever had a serious injury to your head or mouth?			

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?			
Are you in good health?			
Has there been any change in your general health within the past year?			

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?			

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? | | | |

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?			
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?			
Do you use tobacco (smoking, snuff, chew, bidis)?			
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?			
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?			
Number of weeks: _____			
Taking birth control pills or hormonal replacement?			
Nursing?			

Allergies - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics_____			
Aspirin _____			
Penicillin or other antibiotics_____			
Barbiturates, sedatives, or sleeping pills _____			
Sulfa drugs _____			
Codeine or other narcotics _____			
Metals_____			
Latex (rubber) _____			
Iodine _____			
Hay fever/seasonal _____			
Animals_____			
Food _____			
Other _____			

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve			
Previous infective endocarditis			
Damaged valves in transplanted heart			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.			
Angina			
Arteriosclerosis			
Congestive heart failure			
Damaged heart valves			
Heart attack			
Heart murmur			
Low blood pressure			
High blood pressure			
Other congenital heart defects			
Mitral valve prolapse			
Pacemaker			
Rheumatic fever			
Rheumatic heart disease			
Abnormal bleeding			
Anemia			
Blood transfusion			
If yes, date:_____			
Hemophilia			
AIDS or HIV infection			
Arthritis			

	Yes	No	DK
Autoimmune disease			
Rheumatoid arthritis			
Systemic lupus erythematosus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Tuberculosis			
Cancer/Chemotherapy/ Radiation Treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type I or II			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders			
If yes, specify:_____			
Sleep disorder			
Mental health disorders			
Specify:_____			
Recurrent Infections			
Type of infection:_____			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/ migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?			

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____

Thank you for choosing **2nd Street Dental, LLC** as your dental provider. We are committed to your treatment being successful. Please understand that payment of your fees is considered part of your treatments. The following is a statement of our Financial Policy, which we ask that you read and agree to sign prior to treatment.

*All patients must complete the Notice of Privacy Practices, Patient Information Form, HIPPA form, and Medical Health History Forms before seeing the doctor.

*Please be aware that patients only are allowed in the operatory. This includes children. I understand this. (Please sign)_____.

*Missed appointments- It is office policy to call and confirm dental appointments the business day prior to the appointment. Thus, **unless cancelled at least 24 hours in advance, we charge for missed appointments.** Please help us to better serve you and others by keeping a scheduled appointment or by letting us know in advance if that appointment needs to be changed.

Please be aware that confirmed no call/no show appointments are grounds for dismissal from the practice. I have read and understand this. (Please initial)___

We expect payment rendered at time of services. As a courtesy to you, we will file your insurance claim with your provider and they will reimburse you. It is important that you are aware that having insurance is not a guaranteed form of payment. Please realize that some and perhaps all of the services provided may not be covered. Forms of payment include cash, debit card, Visa, MasterCard, and CITI Health Care Card- *subject to credit approval*.

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of

(Name of Patient)_____'s dental needs.

1) Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
2) I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications if I so choose.
3) I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying our my treatment, payment, and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.
4) I, the undersigned patient/guardian, agree to pay for all services that are rendered to myself or the patient immediately upon demand by 2nd Street Dental, LLC. I further agree that in the event of non-payment to 2nd Street Dental, LLC of any amounts under this agreement, I will pay interest at the rate of 15% on all amounts due, a late fee of $25 per month until paid in full, and all attorney fees and court costs that may be incurred. I further agree that in the event that 2nd Street Dental, LLC assigns this account to an agent for collections, I promise to pay an additional collection fee of 40% of any unpaid balance.

I have read this agreement and understand its provisions.

_____

Patient of Parent/Guardian Signature Relationship to Patient Date

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS FORM CAREFULLY, THE PRIVACE 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 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 October 8, 2012, 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 our 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 the 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.

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 practicioner 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, and 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 written authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Unless you give us 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 the health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having a lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or receive 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 on this Notice. You may also request access by sending a letter to the address at the end of this Notice).

Disclosure Accounting: If you request to receive copies of your health information more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be made in writing and must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be made 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 website or by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you would like additional information about our privacy practices or have questions or concerns, please call us at (307) 337-3717.

If you are concerned that we may have violated your privacy rights, or your disagree with a decision we have made about your access to your health information or in a response to a written request to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an alternative location, you may file a complaint in writing with our office. You may also file a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address at which to file that complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if your choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgment

I hereby acknowledge that I have received a copy of 2nd Street Dental, LLC's Privacy Practices.

Signature of the Patient or Guardian if under 18:_____

Please Print Name:_____

Date:_____

FOR OFFICE USE ONLY:

We attempted to obtain acknowledgement of receipt of Our Notice of Privacy Pracitces, but acknowledgement could not be obtained due to the following:

- o Individual refused to sign
- o Communication barriers prohibited understanding of the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other: (please specify):_____

2ND STREET DENTAL, LLC
MIRANDA HAEFELE, D.D.S.

No Show & Cancellations

We would like to thank you for choosing our office. We value your dental treatment and time as we are sure you do ours.

In our office we have a 3 times of missed appointments or no call within 24 hours; you will not be allowed to continue your dental care in our office.

- **Strike 1** = missed appointment /no call = no show is a **warning**.
- **Strike 2** = Missed appointment /no call = no show is a fee **$35.00**.
- **Strike 3** – Missed appointment /no call = no show is grounds for **DISMISSAL!!**

*** IF YOUR APPOINTMENT IS A 7:00 AM OR 8:00 AM YOU WILL BE CHARGED A $70.00 FEE FOR MISSING!!!

We appreciate the opportunity to serve you and your family,

Thank you,

_____

Patient Name printed

_____ _____

Patient Signature Date