Date_____

MEDICAL HISTORY FORM

Patient Information:

Patient's Name:_____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address: _____ SSN:_____ - ____ - _____ Date of Birth: _____/_____ / ____ Age: _____

Sex: ☐ M ☐ F Home No: _____ Cell No: _____ Alt. No: _____

Parent/Guardian Insurance Information: *Relationship to Patient:* _____ ☐ SELF

Name: _____
Last First Middle Initial

SSN:_____ - _____-_____ Insurance No.: _____ Driver License No.:_____

Date of Birth: _____ / ____ / _____ Insurance Telephone No.: _____ Group No.: _____
Employer: _____ Address: _____
Home No: _____ Cell No: _____ Work No: _____
Name and Number of nearest relative not living with you: _____

How did you hear about us? Please mark below:

☐ Online ☐ Flyer / Mail ☐ Printed Ad ☐ Billboard
☐ Radio ☐ TV ☐ Community Event ☐ Health Fair / Screening
☐ Dr. Referral ☐ Driving / Walking by the Office ☐ Medicaid ☐ Insurance / Employer
☐ Friend / Relative ☐ Employee ☐ Other (Specify) _____

Reason for today's dental visit: _____Date of last dental visit: _____
Have you ever had an experience in a dental office that you would like to tell us about? ☐ **Yes** ☐ **No**
Please explain if yes:_____

Are you nervous about dental treatment? ☐ **Yes** ☐ **No**
Do your gums bleed, feel tender or irritated? ☐ **Yes** ☐ **No**
Are you unhappy with appearance of your teeth? ☐ **Yes** ☐ **No**
Are your teeth sensitive? ☐ **Yes** ☐ **No**
Do you have discolored teeth that bother you? ☐ **Yes** ☐ **No**
If yes, to what? ☐ **Sweets** ☐ **Hot** ☐ **Cold** ☐ **Pressure**
Are you now seeing a physician? ☐ **Yes** ☐ **No** The name & telephone number of your physician(s)_____
If so, what is the condition being treated? _____
Are you taking any medications? ☐ **Yes** ☐ **No** If yes, please list: _____
Have you or are you currently taking Aspirin? ☐ **Yes** ☐ **No**
If female, are you or do you suspect to be pregnant? ☐ **Yes** ☐ **No** Months: _____
Have you or are you currently taking oral Bisphosphates? ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelif ☐ Didrone ☐ Other _____
Have you had any joint replacements? ☐ **Yes** ☐ **No** If yes, when? _____
Is there anything else we should know about your health that was not covered on this form? ☐ **Yes** ☐ **No**
If yes, Please explain: _____

Please mark any of the following which you have had or have at present: ☐ NONE

☐ Heart Disease ☐ Anemia ☐ Nervousness ☐ HIV + AIDS
☐ Heart Murmur ☐ Kidney Trouble ☐ Thyroid Disease ☐ Hepatitis
☐ High Blood Pressure ☐ Bone Loss ☐ Chemo: (Cancer, Leukemia) ☐ Hemophilia
☐ Blood Disease ☐ Epilepsy or Seizures ☐ Arthritis ☐ Sickle Cell Disease
☐ Rheumatic Fever ☐ Ulcers ☐ Rheumatism ☐ Bruise Easily
☐ Venereal Disease ☐ Emphysema ☐ Cortisone Medicine ☐ Pain in Jaw Joint
☐ Heart Pacemaker ☐ Tuberculosis ☐ Joint Replacement ☐ Diabetes
☐ Asthma ☐ Scarlet Fever ☐ Hay Fever ☐ Glaucoma

Please mark any of the following medical allergies: ☐ NONE

☐ Local Anesthetics ☐ Penicillin ☐ Codeine or other narcotics ☐ Fen-Phen
☐ Aspirin ☐ Other antibiotic: ☐ Barbiturates or sedatives ☐ Other: _____
☐ Iodine ☐ Sulfa Drugs ☐ Latex ☐ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

_____
Signature of Patient/Parent/Guardian

Medical History Update:

Dr. Date Dr. Date Dr. Date

MELISSA
DENTAL &
ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

I have read and understand the above information.

_____ _____
Patient Signature Date