ST. ALBANS DENTAL

**ABOUT YOU**

Today's Date:_____/_____/_____

Name:_____

**I prefer to be called:**_____

SS#:_____

Birth date:_____ Age:_____

⏭Male ⏭Female ⏭Gender Neutral

Home Address: _____

_____

Cell #:_____

E-mail Address:_____

How do you prefer to be contacted?

⏭E-Mail ⏭Phone ⏭Text

Employer:_____

Occupation:_____

⏭Single ⏭Married ⏭Divorced/Separated

Other family members seen by us:

_____

Previous/Present Dentist_____

Last Visit: _____

How did you find out about us?

⏭Friend ⏭Family ⏭Google

⏭Facebook ⏭Yelp ⏭Other

Whom may we Thank for referring you?

_____

**SPOUSE INFORMATION**

His/Her Name:_____

Employer:_____

SS#:_____

Birth date:_____

**Person Responsible for Account:**

⏭Self ⏭Spouse ⏭Other *(See below)*

*If Other, please continue:*

Name: _____

Cell #:_____

Billing Address: _____

_____

Relation:_____

SS#:_____

**INSURANCE COVERAGE**

**Primary**

Dental Coverage: ⏭YES ⏭NO

Insurance Co.: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone #:_____

Group #: _____

Insured's Name: _____

Relation: ⏭Self ⏭Spouse ⏭Child ⏭Other:_____

Insured's Birth Date: _____/_____/_____

Insured's ID/SS#: _____

Insured's Employer:_____

**Secondary** (if applicable)

Dental Coverage: ⏭YES ⏭NO

Insurance Co.: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone #:_____

Group #: _____

Insured's Name: _____

Relation: ⏭Self ⏭Spouse ⏭Child ⏭Other:_____

Insured's Birth Date: _____/_____/_____

Insured's ID/SS#: _____

Insured's Employer:_____

**EMERGENCY CONTACT**

In the event of an emergency, is there some who lives near that we should contact?

His/Her Name:_____

Cell #: _____

Relationship: _____

**MEDICAL HISTORY**

Name:_____

Do you have a personal physician? ⏭YES ⏭NO

Physician's Name:_____

Phone #: _____

**DENTAL HISTORY**

Why have you come to the dentist today?

_____

Do you require antibiotics before dental

Date of last visit: _____
Are you currently under the care of a physician? ⏭YES ⏭NO
(*If yes, please explain:* _____)
Your current physical health is: ⏭Good ⏭Fair ⏭Poor
Are you taking an prescription, over-the-counter or herbal supplement drugs? ⏭YES ⏭NO
Please list each one: _____

Have you ever taken Fosamax, or any other Bisphosphonate? ⏭YES ⏭NO

**For Women:**
Are you pregnant? ⏭YES ⏭NO Week #:_____
Are you nursing? ⏭YES ⏭NO

| | |
|---|---|
| treatment? | ⏭YES ⏭NO |
| Are you currently in pain? | ⏭YES ⏭NO |
| Do your gums ever bleed? | ⏭YES ⏭NO |
| Have you ever had a serious/difficult problem associated with any previous dental work? | ⏭YES ⏭NO |
| Do you now or have you ever experiences pain/discomfort in your jaw joint (TMJ)? | ⏭YES ⏭NO |
| Do you smoke or use tobacco in any form? | ⏭YES ⏭NO |

Your current dental health is: ⏭Good ⏭Fair ⏭Poor

| | |
|---|---|
| Do you like your smile? | ⏭YES ⏭NO |
| Would you like whiter teeth? | ⏭YES ⏭NO |
| Would you like fresher breath? | ⏭YES ⏭NO |

**Have you ever had any of the following diseases or medical conditions?**

- ❑ Abnormal bleeding
- ❑ Alcohol/Drug use
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial joints/valves
- ❑ Asthma
- ❑ Blood Transfusions
- ❑ Breathing Problems
- ❑ Cancer/Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Disease
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ GERD
- ❑ Hay fever
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis (A, B or C)
- ❑ Herpes/Fever Blisters
- ❑ High Blood Pressure
- ❑ HIV+/AIDS
- ❑ Hospitalized for any reason
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Rheumatic/Scarlet Fever
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Shingles
- ❑ Sleep Apnea
- ❑ Sickle Cell Disease/Trait
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis (TB)
- ❑ Ulcers

Please list any serious medical condition(s) that you have ever had:
_____
_____

How many times a week do you floss? _____
How many times a day do you brush? _____
Type of Bristles? ⏭Soft ⏭Medium ⏭Hard

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this o ce of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover

_____
Signature Date

*Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.*

**Are you allergic to any of the following?**

- ❑ Aspirin
- ❑ Codeine
- ⏭ Dental Anesthetics
- ⏭ Erythromycin
- ❑ Jewelry/Metals
- ❑ Latex
- ⏭ Penicillin
- ⏭ Tetracycline

Please list any other drugs/materials that you are allergic to: _____

## NOTICE OF PRIVACY POLICIES

**Health Insurance Portability Accountability Act (HIPAA), 1996**
**http://www.hhs.gov/ocr/hipaa/finalreg.html**

**Name: _____ Phone: _____**

**Address: _____**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**CONSENT FOR TREATMENT:**
I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

**YOUR RIGHTS:**
You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

**Signature:_____**

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**FOR OFFICE USE:**
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❑ An emergency situation prevented us from obtaining

❑ Other (Specify)