HEALTH HISTORY INFORMATION
(Please check those that apply)

- ☐ AIDS
- ☐ Allergies: _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Birth Control
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocarditis
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Chronic Fatigue
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Other_____
- ☐ Joint Replacement (Hip, Knee, Etc.)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant (Presently) Due Date:_____
- ☐ Chemotherapy
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever w/rheumatic heart disease
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Taking a Blood Thinner
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy or Sensitivity
- ☐ Fibromyalgia
- ☐ Unexplained Weight Loss

What medications are you presently taking? _____
Do you take aspirin or blood thinning medication? _____
Do you take vitamins or supplements? _____
Do you take bone enhancement medication such as Fosamax? _____
Health condition not listed above? _____
Do you smoke or chew tobacco? _____How much per day? _____
Do you consume alcoholic beverages? _____ How much per day? _____
Do you participate in recreational drug use? _____
Have you had prolonged bleeding requiring special treatment? _____
Have you been hospitalized in the last 3 years? If so, when and for what? _____
Have you ever had any cosmetic surgery? _____Cosmetic dental work? _____
How do you take care of your teeth? _____Floss? _____ How often? _____
Do your gums ever bleed? _____
Does food lodge between your teeth? _____
Do you feel you have unpleasant breath or taste in your mouth? _____
Are you aware of grinding or clenching your teeth? _____
Any popping, clicking or snapping noises when you chew or open/close your mouth? _____
Do you have headaches? ____earaches? ____ringing? ____How often? _____Where? _____
Are you aware of sore muscles in your jaw or side of your head? _____
Are you presently under the care of a physician? _____

Physician's Name _____ **Phone #** _____
To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next visit.

Signature:_____**Date:**_____

Please print Patient Name Here: _____

SOMMERS FAMILY DENTISTRY, DDS

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer