Medical History

Patient Name:_____ Birth Date:_____

Address:_____ Phone #_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all of the following questions.

Are you under the care of a physician?..... **Yes** ☐ **No** ☐

If yes, what is his/her name and please explain:_____

_____

Have you ever been hospitalized?..... **Yes** ☐ **No** ☐

If yes, please explain:_____

_____

Have you ever had a serious head or neck injury?..... **Yes** ☐ **No** ☐

If yes, please explain:_____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina (Chest Pains)
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Hearth Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in the Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of the limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ **Sleep Disorder**

Joint Replacement:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? **Yes** ☐ **No** ☐

Date:_____ If yes, have you had any complications? _____

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

(More continued on the next page)

Have you ever had any serious illness not listed above?

_____

_____

Are you taking any **medications, pills, or drugs?**.....**Yes** ◻ **No** ◻

If yes, medication name(s) and please explain:_____

_____

Do you take or have you taken any **Bisphosphonates** such as FosaMax or Boniva.....**Yes** ◻ **No** ◻

Are you on a **special diet?**.....**Yes** ◻ **No** ◻
Do you use **tobacco?**.....**Yes** ◻ **No** ◻
Do you use **controlled substances?**.....**Yes** ◻ **No** ◻

Are you **allergic** to any of the following?
◻ Aspirin ◻ Penicillin ◻ Codeine ◻ Local Anesthetics ◻ Latex ◻ Sulfa Drugs

◻ Other:_____

Women Only: Are you any of the following?
◻ Pregnant/Trying to get pregnant ◻ Taking Oral Contraceptives ◻ Nursing

What is your main concern with your oral health/teeth/smile?

_____

_____

When was the last time you saw a dentist?_____

What did you have done?_____

Are you in any pain today?.....**Yes** ◻ **No** ◻
Is your water supply at home fluoridated? .....**Yes** ◻ **No** ◻

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:_____

Date:_____

Referral Information

Whom may we thank for referring you to our practice: ☐ Another patient ☐ Friend ☐ Relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, 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, of any dental services performed without previous financial arrangement, must be paid for with cash, check, or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, parent or guardian

Payment Authorization
Signature on File

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of information to all my insurance carriers.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize my Doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize payment directly to my Doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Name: (Print)

_____

Signature:

_____ **Date:** _____

OVER→

Patient Information

Patient Name _____ Date _____
Last First MI (Preferred Name)

Gender:_____ Family Status: _____

Social Security # _____ Birth Date: _____

Phone (Home) _____ (Work) _____ Ext.:_____ Best time to call:_____

Cell Phone # _____ (Other) _____

Address: _____
(Street) (Apartment #)

_____
(City) (State) (Zip Code)

Employer Name: _____ Occupation:_____

Address: _____
(Street) (City) (State) (Zip Code) Phone #

May we contact you by E-Mail to confirm your appointments? ☐ Yes ☐ No

If so, what is your E-Mail address: _____

Who may we contact in case of Emergency: _____ Phone# _____

Responsible Party (Guarantor) Information (if different from above)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext: _____ Best time to call:_____

Address: _____
(Street) (Apartment #)

_____
(City) (State) (Zip Code)

Employer Name: _____ Occupation:_____

Address: _____
(Street) (City) (State) (Zip Code) Phone #

Dental Insurance Information

Primary Information:

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last) (First) (MI)

Insured's Birth Date: _____ ID# _____ Group # _____ SS# _____

Insured's Address: _____
(Street) (City) (State) (Zip Code)

Insured's Employer Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last) (First) (MI)

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____
(Street) (City) (State) (Zip Code)

Insured's Employer Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

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: _____ Phone #:

Name: _____ Relationship: _____ Phone #

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

Take our...

SMILE ASSESSMENT

Name_____ Date _____

Yes	No	
☐	☐	Are you comfortable showing your teeth when you smile?
☐	☐	Are you happy with the appearance of your teeth?
☐	☐	Do you have unsightly crowns or fillings?
☐	☐	Can you eat hot or cold foods without experiencing tooth sensitivity?
☐	☐	Are you happy with the length of your teeth (neither too long nor too short)?
☐	☐	Do you like the color of your teeth?
☐	☐	Do you have a complete smile (28 or more teeth)?
☐	☐	Are you interested in improving the appearance of your teeth?
☐	☐	Are you familiar with the benefits of dental implants?
☐	☐	Are your gums healthy (not receding, bleeding or swollen)?
☐	☐	Are you happy with the alignment of your teeth?
☐	☐	Are you anxious or fearful of treatment?

Please list any additional comments or concerns:

_____

_____

_____

_____

SOMMERS FAMILY DENTISTRY, DDS

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