Health History Form

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?	☐	☐	☐

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

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

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?

	Yes	No	DK
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:

____

____

____

____

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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: ____________

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.

Allergy	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.

Condition	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.

Condition	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	☐	☐	☐
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	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

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:____________

Written Financial Policy

Cancellation Policy

Thank you for choosing us for your dental needs. We promise to always offer you state of the art dentistry and the best preventative care. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering a choice of convenient payment options. Please read and sign the following:

Payment:
Payment is due in full at the time services are rendered.
You can choose from:

- Cash-Check- Visa- MasterCard-American Express- Discover
- Care Credit Financing-no interest payment plans (subject to credit approval)
  - 6 Months Deferred Interest for charges $200-$999.
  - 12 Months Deferred Interest for charges $1000 and above.

We offer a 10% courtesy accounting adjustment to non-insurance based patients who pay for their treatment with check or cash at the beginning of their dental care. (Not to be combined)

For those with dental insurance- the above policy is also adhered to on your first visit unless your benefits can be verified by our staff prior to, or by the time the services are rendered. For the first and any subsequent appointments we will collect your initial estimated portion and then bill the insurance company for the treatment. You will be responsible for any outstanding balance following insurance reimbursement.

Short Notice Cancellation & No Show Policy:
While emergencies sometimes do happen, kindly give us 24 hour notice if you must cancel or change your appointment. Without this advance notice, a fee of $50 could be charged to your account.

Dudley Family Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Overdue Balance:
We will send monthly statements to you if your account has an unpaid balance. After 90 days, if we have not received payment or been contacted to make financial arrangements you will be sent to the collection agency.

Returned Checks:
If a check is returned for any reason, there will be a service charge of $25.00 to cover administrative cost levied to us by the bank.

About your insurance benefits:

Our office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that may apply to the benefits provided. **Dental insurance is a contract between YOURSELF and the insurance company.** To fully utilize your yearly insurance benefits, please plan ahead. We encourage you to make your appointments early enough in the year to allow sufficient time to complete your treatment. Do not get caught in the year-end rush.

We have made a commitment to only provide the best care to our patients. We do stand behind our work and do what is right for our patients, but we can only do that if you also commit to taking care of your dental health after our work is done. You must commit to regular dental checkups at least 2 times a year and daily preventative home care. We cannot guarantee our work if you do not stay on a regular preventative routine care schedule or show signs of neglect to your oral health.

Consent & Authorization:

I have read and understand the financial policies of Dudley Family Dental. I understand that by receiving treatment for myself or for my dependents I authorize and accept responsibility to pay for such treatment. Fees not covered by my dental insurance will be promptly paid upon notification from this office. Without any reservations, I agree to abide by these policies.

____

Name of Responsible Party, Parent, or Guardian

____________________________________ ____________________

Signature **Date**

Please list all names of your dependents:

____

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Dudley Family Dental

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.

This Notice applies to services furnished by the dentists, dental hygienists and other personnel of Dudley Family Dental. As of April 14", 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and Massachusetts law to maintain the privacy of your health information and to provide you with this Notice of Privacy Rights & Practices.

This document explains in detail how we use your Protected Health Information ("PHI"). PHI is any information about you that could identify you and your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14", 2003 by the Practice.

I. Use and Disclosure FOR TREATMENT, PAYMENT, AND OPERATIONAL PURPOSES

We may use, and with your consent, disclose your PHI for the following purposes:

•Treatment — we keep a record of each visit and/or admission. These records may include your test results, diagnoses, medications or other therapies. In addition, 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.

•Payment — we maintain a record of and may use information related to services and supplies you receive at each visit and/or admission so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payors about an upcoming treatment or service which requires their prior approval and authorization.

• Health Care Operations — we use your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes.

II. USE AND DISCLOSURE WITHOUT AUTHORIZATION OR CONSENT:

A. There are additional times when we are permitted or required to use or disclose medical information without your written authorization or consent. These circumstances are listed below:

- In emergency treatment situations
- If required by law
- To assist incommunicative patients
- For law enforcement
- To protect victims of abuse, neglect or domestic violence
- For public health activities (tracking diseases or medical devices)
- For health oversight activities such as fraud investigations
- For certain judicial or administrative proceedings
- To Workers' Compensation if you are injured at work
- For government functions such as national security & intelligence
- To coroners, medical examiners and funeral directors
- To a correctional institution if you are an inmate
- To avert serious threat to public health or safety

B. We also may disclose PHI (other than Highly Confidential Information described in Section III below) to a family member, relative or friend—or anyone else you identify—as follows: (i) when you are present for, or otherwise available prior to, the disclosure, and do

not object to such disclosure after being given the opportunity to do so; (ii) when you are incapacitated or in an emergency situation if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases we will only disclose the PHI is directly relevant to the person's involvement in your health care or payment related to your health care.

Ill. AUTHORIZATION

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer, except to the extent that we have already taken action in reliance on your authorization,

NOTICE OF PRIVACY RIGHTS & PRACTICES

IV. Please know that federal and state law requires special privacy protections for certain highly confidential information about you including but not limited to: 1) alcohol and drug abuse prevention, treatment and referral, 2) HIV/AIDS testing, diagnosis or treatment, 3) venereal disease(s), 4) genetic testing, 5) research involving controlled substances. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written consent and/or authorization.

YOUR RIGHTS: Under HIPAA, you have the right to request in writing:

- restrictions on how we use or disclose your medical information.
- confidential communications to an alternate phone or address other than your home.
- access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply).
- an amendment to your medical information if you feel you or your health care provider need to make additions or corrections.
- an accounting of disclosures of your medical information for purposes other than treatment, payment, health care operations or made pursuant to an authorization.
- a paper copy of this Notice even if you have received it electronically.
- a revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our facilities and offices, and will be available from your direct treatment provider.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or with the Director. ***Dudley Family Dental and its employees are committed to protecting patient privacy.***

Dudley Family Dental

I, ___________________________ have received a copy of the Dudley Family Dental Notice of Privacy Practice.

I give Dudley Family Dental my permission to confirm the date and time of all dental appointments; We will confirm on your home phone or cell phone unless otherwise notified.

PLEASE BE ADVISED THAT CONFIRMATION CALLS ARE A COURTESY TO OUR PATIENTS. IF WE ARE SHORT STAFFED OR OVERLY BUSY, WE MAY NOT HAVE TIME TO MAKE THESE CALLS. YOU WILL STILL BE RESPONSIBLE FOR YOUR APPOINTMENT.

Dudley Family Dental requires 24 hour notice for any appointment change. If 24 hour notice is not received; there will be a $50.00 charge. This charge is not a covered benefit by your insurance company and will be your responsibility. We will not be able to schedule future appointments until this charge is paid.

Patient, Parent, or Guardian: Date:

______________________________ ____________________

Dependents:

____

____

____

Agreement to Receive Electronic Communication

Patient Name:____________________________________Date of Birth:______________________

(Initial below)

I _____ DO AGREE

I ____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

__________Text Messaging Cell Phone Number:______________________________

__________ Email Email Address:_____________________________________

I would like to receive:

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

Dudley Family Dental |508.943.7001| info@dudleyfamilydentistry.com

Patient/Guardian Signature:______________________________Date:_______________________