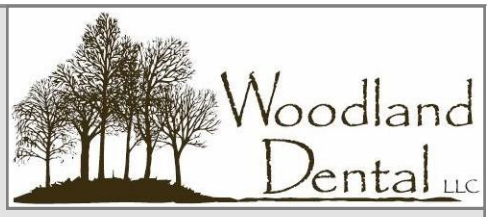
Health History Form



Email: 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.

Patient Information

Patient Name _____ Preferred Name _____ ☐ Female ☐ Male
Last First MI

Date of Birth _____ ☐ Married ☐ Single ☐ Child ☐ Other _____ Social Security Number _____

Home Phone _____ Cell Phone _____ Work _____ Are text reminders okay? ☐ Yes ☐ No

Mailing Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____ Relationship to Patient _____

Emergency Contact _____ Phone _____ Relationship to Patient _____

If you are completing this form for another person, what is your name and relationship to that person? _____
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	☐	☐	☐

Responsible Party Information

Name _____ ☐ Female ☐ Male Social Security Number _____ Date of Birth _____

Address (if different from patient) _____
Street Apt # City State Zip Code

Home Phone _____ Cell Phone _____ Employer Name _____

Insurance Information

Primary
Insurance Plan Name: _____ ID # _____ Group # _____
Policy Holder: _____ Birthday: _____ Social Security # _____

Secondary
Insurance Plan Name: _____ ID # _____ Group # _____

Referral Information

How did you hear about our office?
☐ Another patient-friend ☐ Another patient-relative ☐ Another Dental Office
☐ From Your Insurance ☐ School presentation ☐ Ad Bench
☐ Face Book ☐ Internet ☐ Other

Whom may we thank for referring you to our practice? _____

Dental Information *For the following questions please make (X) your responses to the following questions.*

Patient Name _____

Yes	No	DK		Yes	No	DK		Yes	No	DK	
☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?
☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐	Do your gums bleed when you brush or floss?	☐	☐	☐	Are you currently experiencing dental pain or discomfort?
☐	☐	☐	Is your mouth dry?	☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you have any clicking, or popping or discomfort in the jaw?
☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Have you had any problems associated with previous dental treatment?

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	
☐	☐	☐	Artificial (prosthetic) heart valve
☐	☐	☐	Previous infective endocarditis
☐	☐	☐	Damaged valves in transplanted heart
			Congenital heart disease (CHD)
☐	☐	☐	Repaired CHD with residual defects
☐	☐	☐	Unrepaired, cyanotic CHD
☐	☐	☐	Repaired (completely) in the last 6 months

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes	No	DK	
☐	☐	☐	Cardiovascular disease
☐	☐	☐	Angina
☐	☐	☐	Arteriosclerosis
☐	☐	☐	Congestive heart failure
☐	☐	☐	Damaged heart valves
☐	☐	☐	Heart attack
☐	☐	☐	Heart murmur
☐	☐	☐	Low blood pressure
☐	☐	☐	High blood pressure
☐	☐	☐	Mitral valve prolapsed
☐	☐	☐	Pacemaker
☐	☐	☐	Rheumatic heart disease

Yes	No	DK	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	Anemia
☐	☐	☐	Blood transfusion
			If yes, date: _____
☐	☐	☐	HemophiliaAIDS or HIV infection
☐	☐	☐	Arthritis
☐	☐	☐	Autoimmune
☐	☐	☐	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
☐	☐	☐	Gastrointestinal disease
☐	☐	☐	G.E. Reflux/persistent heartburn
☐	☐	☐	Ulcers
☐	☐	☐	Thyroid problems

Yes	No	DK	
☐	☐	☐	Stroke
☐	☐	☐	Glaucoma
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Neurological disorders
			Specify: _____
☐	☐	☐	Sleep disorder
☐	☐	☐	Do you snore?
☐	☐	☐	Mental health disorders
			Specify: _____
☐	☐	☐	Recurrent Infections
			Specify: _____
☐	☐	☐	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: _____

Please list any medications you are currently taking: _____

OFFICE USE ONLY
Today's blood pressure:

Yes	No	DK	
☐	☐	☐	Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complication? _____
☐	☐	☐	Are you taking or scheduled to be taking an antiresorptive agent (like Fosama, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?
☐	☐	☐	Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began: _____

Yes	No	DK	
☐	☐	☐	Do you use controlled substances (drugs)?
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED
☐	☐	☐	Do you drink alcoholic beverages?
			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.)*

Yes	No	DK		Yes	No	DK	
☐	☐	☐	Local anesthetics _____	☐	☐	☐	Codeine or other narcotics _____
☐	☐	☐	Aspirin _____	☐	☐	☐	Latex (rubber) _____
☐	☐	☐	Penicillin or other antibiotics _____	☐	☐	☐	Food _____
☐	☐	☐	Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐	Other _____

Policies

Patient Name _____

PRIVACY PRACTICES:

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. Our office is required by law to abide by the terms of this notice. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for our purposes that are permitted by law. It also describes your rights to access and control you protected health information. Our office is required to abide by the terms of this notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

How We May Use and Disclose Your Medical Information

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the dentist or assistant, by the business office to process payment for services, and to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders

We may contact you to provide appointment reminders.

Treatment Information

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

Disclosure to Department of Health and Human Services

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.

Legal Proceedings

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Your Rights Regarding Your Medical Information

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charge a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

For more information regarding Privacy Practices and HIPAA please call the HIPAA hotline at 312-440-2899 or by visiting http://hhs.gov/ocr/privacysummary.pdf

INFORMATION GIVEN:

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 information given on this form and that it is accurate. I understand that importance of truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth in this questionnaire have been answered to my satisfaction. I will not hold my dentist, or any other member of his 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.

FINANCIAL OBLIGATIONS:

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, or any dental services performed without previous financial arrangements, must be paid for in cash 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.

Cancellations with less than 48 hour business day or three days notice or failure to show for a scheduled appointment will be charged at $50.00 fee.

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 for 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 the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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. In the event that payment in full, for charges incurred is not made I agree to pay all costs of collection including a 50% collections fee court costs and interest at the rate of 1.5% per month (18%per year).

PERMISSON GIVEN:

Yes No

☐ ☐ I grant my permission for Woodland Dental to use any before and after photos for display.

☐ ☐ I grant my permission to you or your assignee, to telephone, text, leave message with family member, or email me at home or at my work to discuss matters related to this form and to remind me of any upcoming appointments or needed recall appointments.

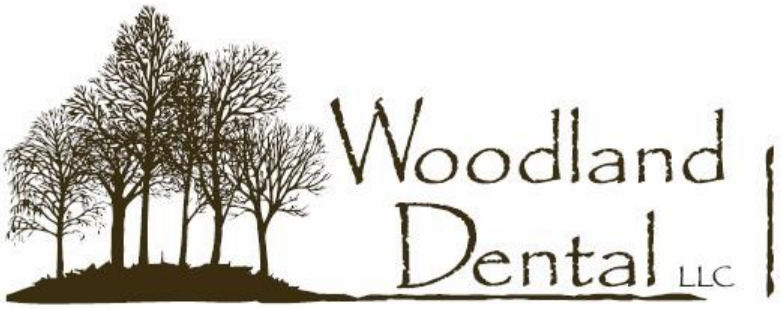
I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient:

Signature of guarantor or payment/responsible party (if different than above) _____ Date: _____

Relationship to Patient:

Signature of Patient/Legal Guardian: _____ Date:_____



David K. Hansen, DMD
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801-423-0905

Information Consent Form

I, _____, give my permission to share information concerning:

- ☐ My dental treatment
- ☐ The costs and financial arrangements for my dental treatment.
- ☐ My personal health information
- ☐ Other

  _____

I give my permission to share the above noted information:

- ☐ My spouse (name) _____
- ☐ My parent(s) (names) _____
- ☐ My adult child or children (names) _____

I, _____, DO NOT give my permission to share ANY information regarding my treatment, financial arrangements or personal health information with the exception of what is outlined in the Woodland Dental HIPPA policy.

Signed: _____ Date: _____

Witness: _____ Date: _____