PATIENT HISTORY AND INFORMATION

(Confidential information for our records)

Patient Information:

Name_____ Today's Date_____

SS#_____ Sex: [] MALE [] FEMALE Date of Birth_____

Current Address _____City_____State____Zip_____

Please indicate best number to reach you

Cell Phone:_____ Home Phone:_____ Msg. Phone:_____

Email:_____

How did you hear about our office? _____

Parent/ Guardian Information (If patient is a minor):

Father's Name_____ Date of Birth_____ SS#_____

Employer_____ Phone #_____ Email_____

Mother's Name_____ Date of Birth_____ SS#_____

Employer_____ Phone #_____ Email_____

Emergency Contact:

1st Emergency Contact_____ Relationship _____

Emergency Contact number _____

2nd Emergency Contact_____ Relationship _____

Emergency Contact number _____

Insurance Information:

Name of Person Insured_____ Relationship to Patient_____
Insured's SS#_____ Insured Date of Birth _____
Insured's Employer_____ Claims mailing address_____
Insurance Company_____ Insurance Phone #_____
Group # _____ ID#_____

Medicaid/AR kids #_____

(CONTINUE ON THE BACK)

Primary Care Physician: _____

Medications: List any medications below you are currently taking:

_____

_____

Allergies: Are you allergic to any of the following? (Circle all that apply)

Aspirin Penicillin Codeine Latex Sulfa Drugs Acrylic Metal Local Anesthetics NONE

Please list any other drug allergies not listed above: _____

Are you under physician's care now? **[| YES [| NO**; If yes, please explain:_____
Have you been hospitalized or had a major operation in the last 5 years? **[| YES [| NO; If yes, please explain:**_____
Have you ever had a serious head or neck injury? **]| YES [| NO**; If yes, please explain: _____
Have you ever taken or are you taking Fosamax, Boniva, Actonel , Aclasta or any other medications containing bisphosphonates?
[| YES || NO ;If yes, when was your last dose?_____
Do you use tobacco? **[| YES [| NO** ; How often? _____
Do you use controlled substances? **[| YES [| NO** ; If yes, what is it?_____ How often? _____

Women: Are you [] Pregnant [] Trying to get pregnant [] Nursing [] Taking Oral contraceptives [] NONE

Y	N		Y	N		Y	N		Y	N	
[]	[]	AIDS/HIV Positive	[]	[]	Easily Winded	[]	[]	Hepatitis A	[]	[]	Recent Weight Loss
[]	[]	Alzheimer's/Dementia	[]	[]	Emphysema	[]	[]	Hepatitis B	[]	[]	Renal Dialysis
[]	[]	Angina	[]	[]	Epilepsy/Seizures	[]	[]	Hepatitis C	[]	[]	Rheumatic Fever
[]	[]	Arthritis/Gout	[]	[]	Excessive Bleeding	[]	[]	Herpes	[]	[]	Rheumatism
[]	[]	Artificial Joint	[]	[]	Excessive Thirst	[]	[]	High Blood Pressur	[]	[]	Scarlet Fever
[]	[]	Asthma	[]	[]	Fainting	[]	[]	Hives or Rash	[]	[]	Shingles
[]	[]	Blood Disease	[]	[]	Spells/Dizziness	[]	[]	Hypoglycemia	[]	[]	Sickle Cell Disease
[]	[]	Blood Transfusion	[]	[]	Frequent Cough	[]	[]	Irregular Heartbeat	[]	[]	Sinus Trouble
[]	[]	Breathing Problems	[]	[]	Frequent Diarrhea	[]	[]	Kidney Problems	[]	[]	Spina Bifida
[]	[]	Bruise Easily	[]	[]	Frequent Headaches	[]	[]	Leukemia	[]	[]	Stomach/Intestinal
[]	[]	Cancer	[]	[]	Genital Herpes	[]	[]	Liver Disease	Disease		
[]	[]	Chemotherapy	[]	[]	Glaucoma	[]	[]	Low Blood Pressur	[]	[]	Stroke
[]	[]	Chest Pains	[]	[]	Hay Fever	[]	[]	Lung Disease	[]	[]	Swelling of Limbs
[]	[]	Cold Sores/Fever Blisters	[]	[]	Heart Attack/Failure	[]	[]	Mitral Valve Prolap	[]	[]	Thyroid Disease
[]	[]	Congenital Heart Disorder	[]	[]	Heart Murmur	[]	[]	Osteoporosis	[]	[]	Tonsillitis
[]	[]	Convulsions	[]	[]	Heart Pace maker	[]	[]	Pain in Jaw Joint	[]	[]	Tuberculosis
[]	[]	Cortisone Medicine	[]	[]	Heart Trouble/Diseas	[]	[]	Psychiatric Care	[]	[]	Tumors or Growths
[]	[]	Diabetes	[]	[]	Hemophilia	[]	[]	Radiation Treatmen	[]	[]	Ulcers
[]	[]	Drug Addiction							[]	[]	Venereal Disease

Please list any other serious illness not listed above, or any other comments here:

_____

_____

_____

_____

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

PRINT PATIENT NAME: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____

SANDLIN
—DENTAL—

OFFICE POLICIES

Appointments and Confirmations (applies to all appointments):
Our Office reserves the right to cancel any appointment that is NOT confirmed 48 hours prior to appointment time. It is the patient's responsibility to keep correct and updated contact information in our office so we have a way of properly contacting you. We also reserve the right to refuse to see any patient who is late for their appointment. Late appointments result in other patients not being seen in a timely manner.

Minor policy (applies to patients under 18):
All patients under the age of 18 MUST be accompanied by a legal Guardian for the duration of their appointment. This policy is in place to provide our staff the opportunity to discuss consent for treatment and also to inform parents of any changes in treatment while patients are being seen in our office.

No one under the age of 18 is to be left unattended in the waiting area. Our office is not responsible for accidents or injuries that may occur if this policy is not followed. Our office strives to keep a safe and secure environment for all of our patients and we appreciate your cooperation.

I have read, understood and agreed to office policies mentioned above.

_____
Child(children's) name(s) (if child is the patient)

_____
Signature of Patient, Parent or Guardian

_____
Date

SANDLIN
—DENTAL—

HIPAA Consent Forms

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 payer (e.g. my insurance company, financing companies, etc);
- 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 bound to comply with this restriction.

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

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature:_____

(FLIP OVER)

SANDLIN
—DENTAL—

By law, without your permission, we <u>cannot</u> speak to the following people:

Spouse Children Caregiver Friends Parents (If you are 18 or older)

Please indicate below anyone that we <u>may</u> communicate with about your appointments, your health or dental information, or your billing account.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you did not list anyone in the above fields, we will only communicate with *you* regarding your appointments, your dental or health information, or your billing account.

If at any time you wish to make changes to this information, please notify a member of our staff.