Health History Form

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.

Patient Information

Name _____ Soc. Sec. # _____

Address _____

_____

Home Phone_____ Cell Phone _____

Sex ☐ M ☐ F Age_____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____

Occupation _____

Employer Address_____ Business Phone _____

Emergency Contact _____ Phone_____

How did you hear about our office?_____

Person Responsible for Account _____
Last First MI

Relation to Patient _____ DOB _____ SS # _____

Address _____
(if different from patient)

City _____ State_____ Zip _____

Email_____ Cell Phone _____

Person Responsible Employer _____

Business Address _____

Business Phone _____

Insurance Company _____ Phone _____

Group #_____ Subscriber # _____

Dependents under this plan_____

Primary Insurance

Dental Information *Please mark (x) for your responses to the following questions.*

	Yes	No
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) treatment?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑
Is your home water supply fluoridated?	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

	Yes	No
Do you have earaches or neck pain?	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑
Do you wear dentures or partials?	❑	❑
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:_____

Medical Information *Please mark (x) for the following questions requiring box responses.*

	Yes	No
Are you now under the care of a physician?	❑	❑

Physician Name: Phone: include area code
_____ (___) _____

Address/City/State/Zip:

_____ _____

	Yes	No
Are you in good health?	❑	❑

Date of last physical exam: _____

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑

If yes, what was the illness or problem?

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:

_____

_____

_____

Medical Information *Please mark (x) for the following questions requiring box responses.*

Family History of:

Diabetes, Heart Disease, Cancer (Circle One)

	Yes	No
Joint Replacement. Have you had an orthopedic total joint		
• (hip, knee, elbow) 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 given 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?	❑	❑

	Yes	No
Do you use controlled substances (drugs)?	❑	❑
Do you use tobacco (smoking, snuff, chew)?	❑	❑
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:	Yes	No
Local anesthetics _____	❑	❑
Aspirin _____	❑	❑
Penicillin or other antibiotics _____	❑	❑
Barbiturates, sedatives, or sleeping pills _____	❑	❑
Sulfa drugs_____	❑	❑
Codeine or other narcotics _____	❑	❑

	Yes	No
Metals _____	❑	❑
Latex (rubber)_____	❑	❑
Iodine _____	❑	❑
Animals _____	❑	❑
Food _____	❑	❑
Other _____	❑	❑

Please mark (x) for your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Artificial (prosthetic) heart valve	❑	❑
Previous infective endocarditis?	❑	❑
Congenital heart disease (CHD)	❑	❑
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	❑	❑
HIV infection or AIDS	❑	❑
Arthritis	❑	❑
Autoimmune disease	❑	❑
Rheumatoid arthritis	❑	❑
Systemic lupus erythematosis	❑	❑
Asthma	❑	❑
COPD	❑	❑
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	❑	❑
Seasonal Allergies	❑	❑
Glaucoma	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
Epilepsy	❑	❑
Fainting spells or seizures	❑	❑
Neurological disorders	❑	❑
if yes, specify:_____		
Sleep disorder	❑	❑
Mental health disorders Specify:_____		
Kidney problems	❑	❑
Night Sweats	❑	❑
Osteoporosis	❑	❑
Severe headaches/ migraines	❑	❑
Severe or rapid weight loss	❑	❑
Sexually transmitted disease	❑	❑

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? ❑ ❑

Please Explain:_____

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:_____

_____

Reviewed By Doctor:_____ Date: _____

We are pleased to welcome you to our practice. Our primary goal is to provide you with superior dental care, which will improve your dental health and comfort. Most procedures are booked well in advance and **your appointment time is reserved exclusively for you.** In fairness to our patients and staff we have implemented a cancellation / payment policy as follows:

- A 48 hour notice is required to cancel or reschedule most appointments. For all major treatment, a seven working day notification is required. A fee may apply.

- **All payments, co-payments and deductibles, are due at the time of service.** We accept cash, checks, MasterCard, Visa and Discover. We also offer CareCredit and Chase Health to help make your care more affordable.

- As a courtesy, our office will processes your dental claims and do everything possible to obtain the maximum coverage to which you are entitled. In order for us to simplify this process, we must have a current copy of your dental insurance card. *We do not bill Medicare or any medical insurance companies. However, we will provide you with a receipt upon request so you may do so.*

- If your insurance has not paid your claim within 60 days, the balance will become your responsibility and payment is required in full including 2% finance charges on any balance owed after 60 days.

- In certain circumstances, a credit card number or down payment may be required to schedule major treatment and or longer appointments.

- Patients will be responsible for any and all expenses involved in the collection of their outstanding and delinquent accounts (i.e. finance charges, collection fees, court cost, etc.).

- A $50.00 returned check fee will be charged for any check, which is returned due to insufficient funds, stop payment or closed accounts.

Thank you for taking the time to read and understand our Payment Policy. Please let us know if you have any questions before signing below.

I hereby state that I have read and understand this financial policy sheet, and agree to the terms of this policy.

X_____ Date_____

Signature of patient or responsible party

Web: PremiereDentalArts.com Email: info@PremiereDentalArts.com Phone: (301) 662-0222

Premiere Dental Arts

Family and Cosmetic Dentistry

Consent to Photograph for Clinical/Diagnostic Purposes

Clinical/Diagnostic use of Pictures & Authorization for use: I understand that pictures of my teeth and gums, my smile, and my face will be taken and used for diagnostic purposes by Premiere Dental Arts. These images will be used to judge clinical progress, aid in the diagnostic evaluation, and assist in treatment planning.

By signing this document, I hereby release to Premiere Dental Arts the rights of my photograph, image, likeness, regardless of format for the purpose of diagnostic evaluation, judging clinical progress, and aiding in treatment planning.

I further acknowledge that:

(1) I am a person of legal age and the person identified below who is authorized to execute this release;

(2) I have read this release in its entirety; (3) I fully understand and accept its terms; and

(4) I have executed this release voluntarily.

_____ _____

Signature Name (Please print)

_____

Signature of parent or legal guardian if under 18 years of age

(_____)_____

Telephone Email Date

_____

Signature of Witness

Dr. Michelle Wear Dr. John Kershner

Premiere Dental Arts
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect as of 10/15/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law, and to make new notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new notice upon request.

You may request a copy of our notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance-abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us for another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third-party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends, or any other individual identified by you when they are involved in your care or in the payment of your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make healthcare decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclosure health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law-enforcement official having lawful custody the protected health information of an inmate or patient.

Security of HHS: We will disclose your health information to the Secretary of U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI (Personal Health Information), to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or an administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and establish protocols to assure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use,

or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access: You have a right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying and for the postage if you want copies mailed to you. Contact us using the information listed at the end of this notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirement in accordance with applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, and (2) whether you want to limit our use, disclosure or both, and (3) to whom you want to the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have

agreed to receive this Notice electronically on our website or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: **SHERRY LEVY**

Telephone: (301) 662-0222
Fax: (301) 662-2034

Address: Premiere Dental Arts
161 Thomas Johnson Drive, Suite 240
21702

EMAIL: info@premieredentalarts.com

Acknowledgement of Receipt of Notice of Privacy Practice

You may refuse to sign this acknowledgement

I, _____have received a copy of the Notice of Privacy Practices.

_____	_____	_____
Print Name	Signature	Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (please specify)