

Patient's Name

Medical Alert

MEDICAL HISTORY

1. Have you ever been under the care of a medical doctor during the past two years? Yes No
If yes, what for _____

Physician's Name _____ Phone _____

2. Have you ever taken medicine for osteoporosis ? Yes No

3. Are you taking any medication, drugs or pills now, including regular dosage of aspirin? Yes No
If yes, please list name and dosage: _____

4. Are you aware of having an allergic (or adverse reaction to any medication or substance? Yes No
If yes, please list: _____

5. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Heart Murmur	Yes	No	Latex Sensitivity	Yes	No
High Blood Pressure	Yes	No	Radiation Therapy	Yes	No
Mitral Valve Prolapse	Yes	No	Chemotherapy	Yes	No
Artificial Heart Valve	Yes	No	Sinus Trouble	Yes	No
Heart Pacemaker	Yes	No	Hepatitis A (infectious) B (serum) C	Yes	No
Rheumatic Fever	Yes	No	Cold Sores/Fever Blisters	Yes	No
Arthritis/Rheumatism	Yes	No	A.I.D.S.	Yes	No
Stroke	Yes	No	H.I.V. Positive	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Bruise Easily	Yes	No
Kidney Trouble	Yes	No	Liver Disease	Yes	No
Diabetes Type 1 Type 11	Yes	No	Epilepsy or Seizures	Yes	No
Thyroid Problems	Yes	No	Nervouse/Anxious	Yes	No
Emphysema	Yes	No	Neurological Disorders	Yes	No
Chronic Cough	Yes	No	Smoke or Chew Tobacco	Yes	No
Tuberculosis	Yes	No			

6. Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list: _____

7. Women Are you: Pregnant? Yes _____ months No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____

Family Dental Care

PRIVACY POLICIES

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.

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its doctors and staff have the necessary medical and PHI to provide the highest quality dental care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its doctors and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its doctors and staff will –

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
 - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- ☞ Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release.

The terms of this notice apply to all records containing your Individually Identifiable Health Information (IIHI) that are created or retained by our practice. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

Dental History

Patient Name

Medical Alert

What are your expectations for your visit today? _____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

On average, how often did you visit your dentist/hygienist? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (interplak, toothpick, etc.) _____

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? _____

Do you have any dental concerns at this time? Yes No

If yes, please describe _____

Have you ever had periodontal treatment? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Do you:

Clench your teeth while awake or asleep? Yes No

Have you ever had a bite plate or mouth guard? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Have clicking or popping of the jaw? Yes No

Have Pain (join, ear, side of face)? Yes No

Please complete the following confidential information

PATIENT REGISTRATION

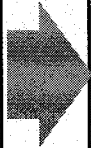
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
PHONE			FAX	
CELL			EMAIL	
BIRTH DATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTH DATE	AGE	MALE	FEMALE	
SCHOOL			GRADE	
SOCIAL SECURITY NO.				

If your child's last name and / or address are not the same as yours, fill in the top box also.

Is another member of your family or relative a patient of our office _____

Who referred you to us? _____

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S ID. NO.		
INSURED'S SOCIAL SECURITY NO.		
SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S ID. NO.		
INSURED'S SOCIAL SECURITY NO.		



CONSENT FOR TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

EMERGENCY CONTACT
 Name _____
 Phone _____
 Relationship _____

Family Dental Care

Receipt of Notice of the Privacy Practices
Written acknowledgement Form
Under Florida State Law

Prudent risk management requires signature to consent Family Dental Care to disclose protected health information (PHI) for use to carry out treatment, payment or health care operations (TPO).

I, _____, have been offered a copy of Family Dental Care's Notice of Privacy Practices, and give consent/acknowledgement and authorization to use or disclose PHI to carry out TPO.

Signature of Patient

Date