

PATIENT NAME _____
 HOME ADDRESS _____

 E-MAIL _____
 EMPLOYER _____
 INSURANCE CO. _____

TODAY'S DATE _____
 DATE OF BIRTH _____
 HOME PHONE _____
 CELL PHONE _____
 BUSINESS PHONE _____
 SS#/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | | | | | | | | | | | | | |
|--|---|---|--------|--------|---|--|---|---|---|---|---|--|--|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO
 If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Do you use alcohol, cocaine or other drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>8. Are you allergic to or have you had any reactions to the following?</p> <table border="0"> <tr> <td>YES NO</td> <td>YES NO</td> <td>YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine)</td> <td><input type="checkbox"/> <input type="checkbox"/> Barbiturates</td> <td><input type="checkbox"/> <input type="checkbox"/> Aspirin</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics</td> <td><input type="checkbox"/> <input type="checkbox"/> Sedatives</td> <td><input type="checkbox"/> <input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs</td> <td><input type="checkbox"/> <input type="checkbox"/> Iodine</td> <td></td> </tr> </table> <p>9. WOMEN ONLY:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | YES NO | YES NO | YES NO | <input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine) | <input type="checkbox"/> <input type="checkbox"/> Barbiturates | <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> <input type="checkbox"/> Sedatives | <input type="checkbox"/> <input type="checkbox"/> Other _____ | <input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> <input type="checkbox"/> Iodine | |
| YES NO | YES NO | YES NO | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Local anesthetics (eg. novocaine) | <input type="checkbox"/> <input type="checkbox"/> Barbiturates | <input type="checkbox"/> <input type="checkbox"/> Aspirin | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> <input type="checkbox"/> Sedatives | <input type="checkbox"/> <input type="checkbox"/> Other _____ | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> <input type="checkbox"/> Iodine | | | | | | | | | | | | |

11. Do you have or have you had any of the following?

- | | | |
|---|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Leukemia | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles / Ulcers | <input type="checkbox"/> <input type="checkbox"/> _____ |

COMMENTS

Signature of Dentist _____ Date _____

PATIENT DENTAL HISTORY

- | | |
|---|--|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <p>a) Clicking? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Pain (joint, ear, side of face)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Difficulty in opening or closing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>d) Difficulty in chewing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. Have you had any orthodontic treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. Have you ever had prolonged bleeding following extractions? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. Have you ever had instruction on the correct method of brushing your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. Have you ever had instructions on the care of your gums? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|---|--|

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE

X _____

PATIENT PARENT OR GUARDIAN

DATE _____

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____ Patient # _____
SS #/SIN _____ Male Female Birthdate _____ Home phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
E-Mail _____ Cell Phone _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient's or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State/Prov. _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____
Parent or guardian signature _____ Date _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
E-Mail _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____

Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of patient or parent/guardian if minor _____ Date _____

Drs. Deines, Huffman and Clark

Name: _____

Date: _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments to complete this profile so we can make you as comfortable as possible.

What is the primary reason for your visit to our office today.

Please rate in order of value, what is most important to you in your dental care.

- _____ Preventive care.
- _____ Only what is necessary at this time, cost is important.
- _____ Comprehensive, quality care. A lifetime plan for dental health.
- _____ Other.

What is the most important to you in your relationship with the dentist.

- _____ Show me what he/she is doing or planning to do so I can clearly see what is happening.
- _____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.
- _____ Make sure I feel comfortable and informed about my treatment.

Please circle the level of fear you have regarding dental treatment. (10 most fearful, 1 being the least fear)

1 2 3 4 5 6 7 8 9 10

I would like to know more about these options to maximize my comfort during my dental visit.

- _____ Sedative medications.
- _____ Nitrous oxide sedation.

Are you concerned about : (please circle)

- | | |
|--------------------------|--|
| Replacing missing teeth. | Bad breath. |
| Eliminating cavities. | Preserving my natural teeth |
| Gum disease. | Replacing old fillings with tooth colored restorations |
| Appearance of my smile | Whitening my teeth . |

I would like to keep my teeth until _____.

When we review your treatment recommendations with you would you like to know: (please check one)

- _____ The big picture of what needs to be done.
- _____ All of the treatment details along the way to completing my care.

Please tell us anything else that you feel will allow us to better serve your dental care needs.

DRS. DEINES, HUFFMAN, AND CLARK
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have reviewed a copy of this office's
Notice Privacy Practices, and will be given a paper copy if requested.

_____ (Please print full 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 acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other reason (please specify below)

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

Dental insurance is rapidly playing a larger and larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to maintain the high quality of care, we would like to share some facts about dental insurance with you...

1. Most dental insurances are *not* meant to be a *PAY-ALL*, they are only meant to be an aid
2. Many plans tell their insured that they will be covered "up to 80% or up to 100%". In spite of what you are told, we have found many plans only cover about 40-50% of an average fee. Some plans pay more, some plans pay less. The amount your plan pays is determined by how much you and your employer pay for the plan. The less paid for the insurance, the less you will receive.
3. It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than "our benefits are low". Remember, you get back only what you and your employer put in, less profits of the insurance company.
4. All dental plans have a maximum allowance per year. Treatment which exceeds this amount is not covered.
5. Many routine dental services are *NOT* covered by insurance policies, especially under medical policies. This includes dental X-rays.

FACTS YOU SHOULD KNOW ABOUT OUR PAYMENT POLICY

We promise to base your treatment on your personal dental health needs, not on your insurance policy. Your level of insurance coverage is determined by the policy your employer has purchased. Your yearly maximum may be insufficient to cover all needed treatment. Although you may have insurance coverage, some procedures are not covered or a co-payment is required. You are the most important person regarding your health. After consulting with us, you ultimately decide whether a treatment is right for you at this time. Therefore, you are responsible for payment regardless of your insurance coverage.

ALL ACCOUNTS ARE CONSIDERED PAYABLE UPON COMPLETION OF SERVICES. REGARDLESS OF INSURANCE COVERAGE, ALL ACCOUNTS MUST BE -- PAID IN FULL -- NO LATER THAN 90 DAYS FROM SERVICE. ACCOUNTS MUST BE KEPT CURRENT AT ALL TIMES.

PLEASE DO NOT HESITATE TO ASK US ANY QUESTIONS ABOUT OUR OFFICE POLICIES. We want YOU to be comfortable in dealing with these matters and we URGE you to consult us if you have any questions regarding our services. We will fill out and send your insurance claims for you as a *courtesy*.

APPOINTMENT POLICIES

We work by appointment only, and that specific period of time is reserved especially for you, dependent on the procedure to be done. When it is necessary for you to change an appointment, 24 hours advance notice is requested. This enables us to offer your reserved time to waiting patients. Failure to notify us of your inability to keep your appointment reservation will force us to make a charge for the lost time.

Except in emergency situations, you may expect us to be on time for your scheduled appointment and the same courtesy would be appreciated of you. We are morally obligated to treat emergencies and ask your indulgence under such conditions.

 Patient or Guardian Signature

 Date

Authorization for Release of Information

Name of Patient _____	Date of Birth _____
<p>Drs. Deines, Huffman & Clark is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.</p>	

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____

<p>Patient Information</p> <p>I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</p> <p>I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.</p> <p><i>I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until revoked by the patient.</u></i></p>
--

Date _____

Signature of Patient or Personal Representative _____

Description of Personal Representative's Authority (attach necessary documentation) _____