Dental History

1. Please briefly describe your chief dental complaint /or the reason why you are here. _____

_____

_____

2. When did this problem begin? _____

3. When was the last time you saw a dentist? _____ Did you have a teeth cleaning? ❑ Yes ❑ No

4. Do your teeth hurt? _____

5. Are your teeth sensitive to: heat_____ cold_____ sweets_____ sour_____ pressure_____ air_____

6. Have you ever had an allergic reation to: "Novacaine"_____ Anesthetic_____ Sulphites_____

7. Do you chew on: pens_____ lips_____ tongue_____ cheeks_____ fingernails_____

	Circle
8. Have you had a difficult extraction in the past?	Yes No
9. Have you had prolonged bleeding from an extraction or dental work?	Yes No
10. Do your gums bleed?	Yes No
11. Do you chew on both sides of your mouth?	Yes No
12. Do your teeth hurt when you chew?	Yes No
13. Have you had orthodontics or worn any dental appliance?	Yes No
14. Do you get frequent headaches, earaches, neckaches or pain in the facial area?	Yes No
15. Do you clench or grind your teeth?	Yes No
16. Do you have a hearing loss or ringing in your ears?	Yes No

	Circle
17. Do you have popping, grinding or a click next to your ears when you open your mouth?	Yes No
18. Have you been dissatisfied with any past dental treatment?	Yes No
19. Does food usually wedge between certain teeth?	Yes No
20. Do you have any pain in front of your ears?	Yes No
21. Do your teeth or jaws ever feel "tired or sore" when you wake up in the morning?	Yes No
22. Have you had any teeth removed?	Yes No
Have they been replaced?	Yes No
23. Are you a mouth breather?	Yes No
24. Are you allergic to any metals?	Yes No

26. How do you feel about the way your teeth look? _____

27. Do you smoke? _____

28. Do you floss? _____

Floor of Mouth_____ Vest _____ Saliva _____

Tongue_____ Lips _____ Palate _____ Cheeks _____ Throat_____

Gingival Inflamation heavy ❑ mod ❑ slight ❑

Mucogiingival Defects _____ Overbite _____Overjet _____ Midlines _____ Opening mm _____

Occluson left _____right_____ Range of motion: left _____ right _____

Excursion left balancing_____left working_____ right balancing _____ right working_____

protrusive_____

Muscle Pain_____ Sounds: left_____ right _____

Bruxism _____ Wear Facets_____

Notations (for office use only) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Andrew
SEWELL, DDS

On behalf of the staff we would like to welcome you to our office. Today you will be given a complete examination of your mouth, head, neck, jaw, and occlusion (bite). To aid in this examination and to plan the best treatment for you, it is important to obtain certain information about your dental and medical symptoms. Please answer as many questions as possible.

_____Thank you

Patient Information

Full Name_____ Birthdate_____ Today's Date _____
Home Address _____ City _____ State _____ Zip _____
S.S. #_____ Occupation _____
Employer _____
Home Phone_____ Business Phone_____ Referred By _____
Name of Spouse _____ Work Phone _____
Spouse's Employer _____
Name of nearest relative or friend who is not living with you now, who will always know your whereabouts.
Name _____ Phone (_____) _____
Address_____ City _____ State _____ Zip _____

Do you have dental insurance? ❑ Yes ❑ No Name of Insured _____
If yes, please name your company and policy number.
Company _____ Policy Number _____

Medical History

	Circle
1. Have you been a patient in the hospital during the past two years?	Yes No
2. Have you been under the care of a medical doctor during the past two years?	Yes No
3. Have you taken any medicine or drugs during the past two years?	Yes No
4. Are you allergic to (i.e. itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	Yes No

	Circle
5. Have you had any excessive bleeding requiring special treatment?	Yes No
6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	Yes No
7. Do your ankles swell during the day?	Yes No
8. Do you ever wake up from sleep short of breath?	Yes No
9. Are you pregnant now?	Yes No
10. Do you use birth control pills?	Yes No

11. Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint

Anemia
Stroke
Kidney Trouble
Ulcers
Emphysema
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease

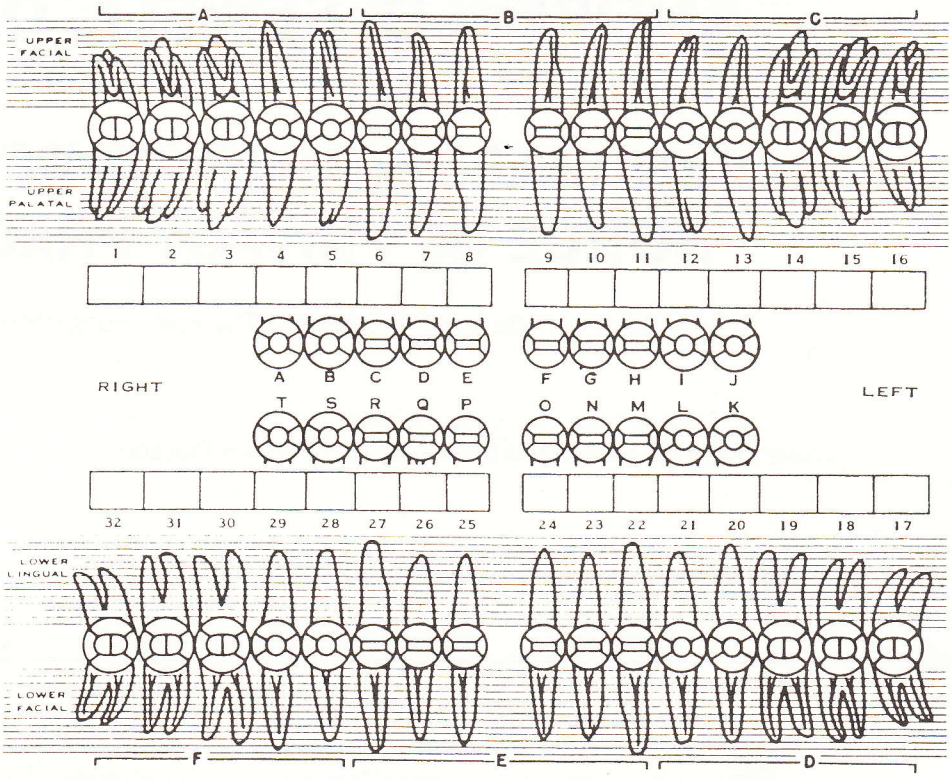
X-ray or Cobalt Treatment
Chemotherapy
(Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
AIDS/HIV
Hepatitis A (Infectious)
Hepatitis B (serum)
Hepatitis C
Liver Disease

Yellow Jaundice
Blood Transfusion
Venereal disease
(Syphilis, Gonorrhea)
Cold Sores
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily

12. Do you have any disease, condition, or problem not listed: _____
13. What medications do you regularly take? _____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at my next appointment without fail.

Date_____ Signature of Patient, Parent or Guardian _____
Dentist Signature _____
Notations (for office use only) _____
_____



Date _____

Number of X Rays _____

Study Models _____

Photos _____

Teeth#	Diagnosis	Teeth#	Diagnosis
1.		17.	
2.		18.	
3.		19.	
4.		20.	
5.		21.	
6.		22.	
7.		23.	
8.		24.	
9.		25.	
10.		26.	
11.		27.	
12.		28.	
13.		29.	
14.		30.	
15.		31.	
16.		32.	

ANDREW D. SEWELL, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I have received a copy of this office's Notice of Privacy Practices.

_____

Please 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 barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____

Sewell Family Dentistry

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. 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.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

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 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 U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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.

Contact Officer: Andrew D. Sewell D.D.S.
Telephone: 303-442-6142
Fax: 303-443-6163

Sewell Family Dentistry
Andrew D. Sewell D.D.S.
General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (parenthesis).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ _____ _____ _____

Patient's signature **Date** **Parent's signature (if minor patient)** **Date**

Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% (eighteen percent) per annum on all such amounts outstanding.

_____

Signature of Patient or Guardian