PATIENT HEALTH RECORD

Date_____

Name_____ Spouse's Name_____
(Last) (First) (Initial)

Address_____

City_____ State_____ Zip Code_____

Business Name_____

Home Phone_____ Business Phone_____

Cell Phone_____ E-mail Address_____

Date of Birth_____ Sex_____ Height_____ Weight_____

Occupation_____ Social Security No._____-_____-_____ Single_____ Married_____

Closest Relative_____ Phone#_____ Cell#_____

Whom may we thank for referring you to us?_____

MEDICAL HEALTH

Name and address of physician_____

Have you been under a physician's care during the past 2 years?_____ For_____

Have you been treated in a hospital in the past 2 years?_____ For_____

Have you ever had major surgery?_____

If female: Are you taking hormones or birth control?_____ Are you pregnant or nursing?_____

Have you ever been exposed to hepatitis?_____ Were you vaccinated?_____

Have you ever had cankers or cold sores on your lips, tongue, gums, or body?_____

Are you now taking or have you taken any prescription medications within the past year? Please list. _____

_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Latex ☐ Other (please list)

_____

Have you had or do you now have:

	yes	no		yes	no
Abnormal blood pressure	☐	☐	Hepatitis	☐	☐
AIDS	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Jaundice	☐	☐
Anemia	☐	☐	Kidney disease	☐	☐
Angina	☐	☐	Liver disease	☐	☐
Arthritis	☐	☐	Organ transplant	☐	☐
Artificial heart valves	☐	☐	Pacemaker	☐	☐
Artificial joints	☐	☐	Polio	☐	☐
Asthma	☐	☐	Prolonged bleeding	☐	☐
Cancer	☐	☐	Prolonged cough	☐	☐
Chemotherapy	☐	☐	Psychiatric treatment	☐	☐
Congenital heart lesions	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle cell anemia	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Ulcers	☐	☐
Heart murmur	☐	☐	Venereal disease	☐	☐

Have you had any disease, condition, or problem not previously listed?_____

_____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot ____ Cold ____ Sweets ____ Chewing _____

How often do you brush your teeth? _____ Floss? _____ Water jet? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you ever had periodontal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____
If so, how? Fixed bridge _____ Removable partial _____ Full Denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

_____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

_____

Have you ever had an unpleasant dental experience? _____

AUTHORIZATION FOR TREATMENT

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those anesthetics or premedications which may be deemed advisable by the doctor. I will be responsible for any financial obligation for treatment on myself or the above named child.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgements on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ACKNOWLEDGEMENTS OF RECEIPT OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for

WOODBINE FAMILY DENTISTRY

this _____ day of _____, 20 _____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

PLEASE PRINT YOUR NAME

_____

PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

_____

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Angela Townley.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

- ❑ It was emergency treatment.
- ❑ I could not communicate with the patient.
- ❑ The patient refused to sign
- ❑ The patient was unable to sign because: _____
- ❑ Other (please describe) _____

Signature of privacy officer _____

WOODBINE FAMILY DENTISTRY

REID HINES, D.M.D. ALAN MCGINNIS, D.M.D.

Patient Information: This section refers to the PATIENT ONLY

First Name:_____ Jr., II, ____ If Employed, Company: _____

Last Name: _____ MI _____ _____

Nickname / Alias: _____ Occupation: _____

Address: _____ Address: _____

Zip Code:_____ City: _____ State: ____ _____

Home Phone: (_____) _____ Zip Code: _____

Work Phone: (_____) _____ Ext _____ City/State: _____

Marital Status: Married Single Divorced Widowed

Birth Date (mm/dd/yy): _____ Sex: ☐ Male ☐ Female If Student ☐ Full-Time ☐ Part-Time

Social Security Number: _____ Name of School: _____

Race: African American American Indian ASian CAucasian HIspanic _____

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name:_____ Jr., II, ____ If Employed, Company: _____

Last Name:_____ MI _____ _____

Address: _____ Address: _____

Zip Code:_____ City: _____ State: ____ _____

Home Phone: (_____) _____ Zip Code: _____

Work Phone: (_____) _____ Ext _____ City/State: _____

Marital Status: Married Single Divorced Widowed

Birth Date (mm/dd/yy): _____ Sex: ☐ Male ☐ Female If Student ☐ Full-Time ☐ Part-Time

Social Security Number: _____ Name of School: _____

Race: African American American Indian ASian CAucasian HIspanic _____

Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS FILED

Relationship to Patient: ☐ Self (skip to page 2) ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name:_____ Jr., II, ____ If Employed, Company: _____

Last Name:_____ MI _____ _____

Address: _____ Address: _____

Zip Code:_____ City: _____ State: ____ _____

Home Phone: (_____) _____ Zip Code: _____

Work Phone: (_____) _____ Ext _____ City/State: _____

Marital Status: Married Single Divorced Widowed

Birth Date (mm/dd/yy): _____ Sex: ☐ Male ☐ Female If Student ☐ Full-Time ☐ Part-Time

Social Security Number: _____ Name of School: _____

Race: African American American Indian ASian CAucasian HIspanic _____

Please ensure the office has a copy of your most recent insurance card(s)

Please ensure the office has a copy of your current Drivers License

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s)

PRIMARY INSURANCE COVERAGE:

Insured (Name on card) _____ Social Security Number _____

Date of Birth _____

Insurance Co. Name _____ Group/Member/Policy Number _____

Address: _____ Effective Date: _____

SECONDARY INSURANCE COVERAGE:

Insured (Name on card) _____ Social Security Number _____

Date of Birth _____

Insurance Co. Name _____ Group/Member/Policy Number _____

Address: _____ Effective Date: _____

I understand and agree that Dental and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Dental Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Dental Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Parent or Guardian's Signature: _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of **WOODBINE FAMILY DENTISTRY** to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

_____ _____

Date Signature of Patient and/or Guardian, if patient is Minor

APPOINTMENTS

OFFICE HOURS ARE MONDAY THRU FRIDAY 7:00 A.M. TO 12:00 P.M. AND FROM 1:00 PM TO 4:00 PM.

WE ASK THAT WITH ANY CANCELLATION WE ARE NOTIFIED AT LEAST 24 HOURS IN ADVANCE. IF YOU HAVE TWO (2) MISSED APPOINTMENTS WITHOUT THE 24 HOUR NOTICE, YOU WILL BE CHARGED A $25 FEE, AND NO NEW APPOINTMENTS WILL BE MADE UNTIL THIS FEE HAS BEEN PAID.

DATE _____ SIGNATURE _____

PATIENT / PARENT OR GUARDIAN