

PATIENT INFORMATION & HEALTH HISTORY

Legal Name: _____ Gender: _____ Birthdate: _____ Age: _____

By what name would you prefer to be called? _____ Marital Status: S M D W

Local Address _____ Local Phone: _____
STREET CITY STATE ZIP

Social Security # _____ Occupation _____ Cell Phone: _____

Employer _____ Work Phone: _____

Friend or relative that will be available during your appointments: _____

Relationship to patient: _____ Phone: _____

Person responsible for your account, if other than yourself:

Name _____ Birthdate: _____ Relationship to patient _____

Address _____ Phone: _____
STREET CITY STATE ZIP

Social Security # _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Subscriber Name _____

Subscriber Name _____

Employer _____

Employer _____

S.S.N. _____ D.O.B. _____

S.S.N. _____ D.O.B. _____

Insurance Carrier _____

Insurance Carrier _____

ID #: _____ Group#: _____

ID #: _____ Group#: _____

Address: _____

Address: _____

Phone#: _____

Phone#: _____

Relationship to Subscriber: _____

Relationship to Subscriber: _____

DENTAL INFORMATION

Who Referred You To Our Office: _____

Reason For Today's Visit: _____

Previous Dentist: _____

Name Street City State Phone

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when you brush? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had orthodontic (braces) treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to cold, hot, sweets or pressure? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have headaches, ear, or neck pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any periodontal (gum) treatments? | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear removable dental appliances? |

Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____

Date of your last dental exam: _____ Date of last dental x-rays _____

What was done at that time? _____

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

Have you ever whitened or lightened your teeth? _____

Please list anything else you feel is important for us to know. _____

Do you wish to discuss anything about your medical or dental history with the doctor in private? Yes No

PLEASE COMPLETE THE BACK OF THIS FORM, THEN RETURN TO RECEPTIONIST

MEDICAL INFORMATION

- Yes No
 Has there been any change in your general health in the last year? If yes, please explain: _____
- Are you under the care of a physician? Condition(s) being treated: _____
 Date of your last physical exam: _____ Your physician's name: _____
- Have you had any illness, operation or been hospitalized in the last 5 years? If so, please list the illness or medical problem: _____
- Are you taking any medications? Please list all medications you are taking: _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

- | | | |
|---|--|--|
| Yes No
<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection
<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion
<i>If yes, date(s):</i> _____
<input type="checkbox"/> <input type="checkbox"/> Cancer
<i>If yes, type(s):</i> _____
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy or Radiation
<input type="checkbox"/> <input type="checkbox"/> Cardiovascular Disease
<i>If yes, check all that apply</i>
<input type="checkbox"/> Angina
<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Coronary Insufficiency
<input type="checkbox"/> Coronary Occlusion
<input type="checkbox"/> Damaged Heart Valve
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Inborn (Congenital) Heart Defect
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> <input type="checkbox"/> Chest Pain Upon Exertion
<input type="checkbox"/> <input type="checkbox"/> Chronic Pain
<input type="checkbox"/> <input type="checkbox"/> Persistent Diarrhea | Yes No
<input type="checkbox"/> <input type="checkbox"/> Immunosuppressed
<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> Type 1 (Insulin Dependent)
<input type="checkbox"/> Type 2
<input type="checkbox"/> <input type="checkbox"/> Dry Mouth
<input type="checkbox"/> <input type="checkbox"/> Eating Disorder
<i>If yes, please specify</i> _____
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Siezuers
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells
<input type="checkbox"/> <input type="checkbox"/> GERD
<input type="checkbox"/> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Hemophilia
<input type="checkbox"/> <input type="checkbox"/> Hepatitis, Jaundice, Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Recurrent Infections
<i>If yes, please specify:</i> _____
<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Kidney Problems
<input type="checkbox"/> <input type="checkbox"/> Mental Health Disorders
<i>Please specify:</i> _____
<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> <input type="checkbox"/> Prosthetic Joint
<i>If yes, please specify which joint and date of surgery:</i> _____
<input type="checkbox"/> <input type="checkbox"/> Malnutrition
<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> <input type="checkbox"/> Neurological Disorders
<i>Please specify:</i> _____ | Yes No
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis/Osteopenia
<i>If yes, have you ever taken a Bisphosphonate? (Fosamax/Boniva)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <input type="checkbox"/> Persistent Swollen Glands
<input type="checkbox"/> <input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Severe Headaches
<input type="checkbox"/> <input type="checkbox"/> Unusual Weight Change
<input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> <input type="checkbox"/> Sinus Problems
<input type="checkbox"/> <input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> <input type="checkbox"/> Sores or Ulcers in the Mouth
<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus Eryth.
<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Excessive Urination
<input type="checkbox"/> <input type="checkbox"/> Do you have any disease, condition or problem that we should know about?
<i>Please explain:</i> _____ |
|---|--|--|

WOMEN ONLY:

Yes No
 Pregnant or could be?
 Are you nursing?

Are you ALLERGIC to, or had a bad REACTION to:

- | | | |
|---|---|---|
| Yes No
<input type="checkbox"/> <input type="checkbox"/> Local Anesthetics (Novocaine)
<input type="checkbox"/> <input type="checkbox"/> Codeine/Narcotics
<input type="checkbox"/> <input type="checkbox"/> Metals: _____
<input type="checkbox"/> <input type="checkbox"/> Other: _____ | Yes No
<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Foods: _____
<input type="checkbox"/> <input type="checkbox"/> Preservatives/Additives
<i>If yes to any allergy, please explain the type of reaction:</i> _____ | Yes No
<input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs/Sulfonamides
<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Hay Fever/Seasonal |
|---|---|---|

Please Initial

We will provide your insurance company with any information necessary for you to receive the maximum benefits and reimbursements that your dental insurance will allow. You are responsible for any charges not paid by your insurance. We request that you pay your ESTIMATE for treatment at each appointment.

Missed Appointment Policy: If an appointment has been missed or canceled, with less than 24 hours notice, a fee may be applied. For Monday appointments, cancellations should be made by noon on the preceding Friday.

By signing below, I hereby authorize payment of the dental benefits directly to Phipps, Shevlin, & Associates Family Dentistry, LTD.

Date	Signature of Patient or Guardian	Comments

Phipps, Shevlin, & Associates Family Dentistry

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information ("PHI"). The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Oral Communications:

- Best Contact Number: _____
- O.K. to leave message with detailed information
 - Leave message with call-back number

Written communication:

- Mail
- Email: _____
- Text Messages - Cell Phone Number: _____
- If checked, the following additional instructions apply:

Signature of Patient or Guardian

Date



Phipps, Shevlin, & Associates Family Dentistry

Bowling Green, Ohio 43402

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Phipps, Shevlin, Hebeka General Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Phipps, Shevlin, Hebeka General Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.

Spouse only (please list name)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any member of my immediate Family(please list name): (Spouse, Children, Children's Spouses)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any Member of my extended family (please list name): (Parents, Grandparents)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (please list name):	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Patient (please print):

Patient signature (if 18 years old or older):

Patient's personal representative (please print):

Personal Representative's signature:

Representative's contact number:

Date:

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided prior to treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date Statement Provided:
Reason for not obtaining patient signature	<input type="checkbox"/>	Needed more time to review Statement of Privacy Practices	
	<input type="checkbox"/>	Wanted to consult another person before signing	
	<input type="checkbox"/>	Physically unable to sign	
	<input type="checkbox"/>	No reason offered	
	<input type="checkbox"/>	Other:	