Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Gender: Male / Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship _____ Cancer? Yes No Relationship _____

Heart disease? Yes No Relationship _____ Bleeding problems? Yes No Relationship _____

Tumors? Yes No Relationship _____ Lung disease? Yes No Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. _____	Yes	No
Prescription pain medication?	Yes	No	_ _____ _		

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

Greene Comprehensive Family Dentistry

118 Stoneridge Drive, Suite #A
Ruckersville, VA. 22968

Patient Information

Patient Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Patient SS#: _____ DOB: _____

Drive License #: _____ State of Issue: _____

Financially Responsible Party

Name: _____ Patient Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Insurance Information

Policy Holder: _____ Patient Relation: _____

Policy Holder's DOB: _____ Policy Holder's SS#:_____

Policy Holder's Employer:_____ Work Phone Number: ( )_____

Insurance Company:_____ Phone Number: ( )_____

Group #:_____ Subscriber ID #:_____

Emergency Contact Information

Emergency Contact:_____ Phone Number: ( )_____

Address:_____

City:_____ State:_____ Zip:_____

GREENE COMPREHENSIVE FAMILY DENTISTRY

PATIENT FINANCIAL RESPONSIBILITY

I _____ hereby assign to Greene Comprehensive Family Dentistry all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge that any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Greene Comprehensive Family Dentistry thereafter receives payment from my insurance company, I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s), my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office participates as "Dental Providers" for **Anthem, Cigna Radius, Delta Dental Premier, Guardian, MetLife** and **United Concordia.** If you have dental insurance with companies other than those listed above, you will be responsible for your co-payment **TODAY** according to your dental insurance plan. We will submit today's visit to your insurance company. Also that all estimates for co-payment are **estimates** you are responsible for what your insurance does not pay.

- I agree to pay interest on the total paid monthly balance at the rate of **18.00% APR**, such interest to begin if the **account is thirty (30) days past due** and calculated from the date of service.
- I agree to pay all costs of collections, including, but not limited to, thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filed or not, as well as, all court costs.
- I authorize my employer to release all information regarding employment and salary verification.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept postdated checks.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept payment plans and payment is expected at every appointment unless otherwise stated.
- Broken, missed, or canceled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.
- **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

We are a medical practice and as such we will ask you to complete a Health History Form. We will ask you for updates of your personal and medical information. Please notify our staff if there is a change in your health. Your health information is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35.00 FOR ALL RETURNED CHECKS

_____ _____ _____

Print Name (Patient) Signature of Responsible Party Date

GREENE COMPREHENSIVE FAMILY DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law.
You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice is a member of statewide Prescription Monitoring Program.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

I give my permission to discuss my treatment and or billing information with: _____

Relationship to patient (check one):

❽ Spouse ❽ Parent ❽ Child ❽ Grandparent ❽ Grandchild ❽ Legal Guardian

❽ Attorney (or representative) of patient ❽ Other: _____

This HIPAA Consent was signed by: _____ _____

Signature of patient or guardian — Printed name of same

Relationship to the patient (if other than patient):_____ _____

Please print — Today's Date

Signature of practice representative:_____