HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ SEX: M F

BIRTHDATE _____ Soc. Sec. # _____EMAIL_____

HM#_____CELL#_____WK#_____

PREFERRED method of communication (please circle): HM CELL WK EMAIL

RESIDENCE Street_____Apt#_____

City_____ State_____ Zip_____DL#_____

Who May We Thank for Referring You to our Office?_____

Reason for this Visit_____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____

MARITAL STATUS_____ RESIDENCE Street _____ Apt #_____

City _____ State _____ Zip _____

MAILING ADDRESS (if different from above) Street _____ Apt # _____

City _____ State _____ Zip _____

HOME PHONE _____CELL PHONE _____WORK PHONE_____

EMAIL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE #_____

RELATION TO PATIENT_____

EMPLOYER _____ OCCUPATION_____

RESPONSIBLE PARTY'S SPOUSE

NAME_____

EMPLOYER_____ OCCUPATION _____

SOC. SEC. #_____ BIRTHDATE_____

HOME PH. _____ CELL PH. _____

WORK PH._____

E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME_____

RELATIONSHIP_____

ADDRESS_____

CITY, STATE_____

HOME PH. _____ CELL PH._____

WORH PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name_____

Insurance Co._____

Insurance Co. Address

_____

_____

Insured's Employer

_____

Insured's Soc. Sec. #_____

Subscriber ID#_____

Group #_____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name_____

Insurance Co._____

Insurance Co. Address

_____

_____

Insured's Employer

_____

Insured's Soc. Sec. # _____

Subscriber ID #_____

Group #_____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist?		
City: State: Ph#:		
How do you feel about your teeth?		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.		
FEAR of pain# LACK of concern#		
COST of treatment# MISSING work time#		

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	Y/N		Y/N		Y/N
AIDS/HIV Pos.	☐ ☐	Fainting	☐ ☐	Psychiatric care	☐ ☐
Anaphylaxis	☐ ☐	Food allergies	☐ ☐	Rapid weight gain/loss	☐ ☐
Anemia	☐ ☐	Glaucoma	☐ ☐	Radiation treatment	☐ ☐
Arthritis (Rheumatism)	☐ ☐	Headaches	☐ ☐	Respiratory disease	☐ ☐
Artificial Heart Valves	☐ ☐	Heart murmur	☐ ☐	Rheumatic/scarlet fever	☐ ☐
Artificial joints	☐ ☐	Heart problems (please describe)			☐ ☐
Shingles	☐ ☐	_____			
Asthma	☐ ☐	Shortness of breath	☐ ☐	Atopic (Allergy Prone)	☐ ☐
		Hemophilia (Abnormal bleeding)	☐ ☐	Skin rash	☐ ☐
Back Problems	☐ ☐	Herpes	☐ ☐	Spina Bifida	☐ ☐
Blood Disease	☐ ☐	Hepatitis	☐ ☐	Stroke	☐ ☐
Cancer	☐ ☐	High blood pressure	☐ ☐	Surgical implant	☐ ☐
Chemical dependency	☐ ☐	Jaw pain	☐ ☐	Swelling of feet/ankles	☐ ☐
Chemotheropy	☐ ☐	Kidney disease/malfunction	☐ ☐	Thyroid disease/malfunction	☐ ☐
Circulatory problems	☐ ☐	Liver disease	☐ ☐	Tobacco habit	☐ ☐
Cortisone treatments	☐ ☐	Material allergies	☐ ☐	Tonsillitis	☐ ☐
Cough (persistent)	☐ ☐	(latex, wool, metal, chemicals)		Tuberculosis	☐ ☐
Cough up blood	☐ ☐	Mitral valve prolapse	☐ ☐	Ulcer/Colitis	☐ ☐
Diabetes	☐ ☐	Nervous problems	☐ ☐	Venereal disease	☐ ☐
Epilepsy	☐ ☐	Pacemaker/heart surg	☐ ☐		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Latex	Nitrous Oxide	Codeine
Penicillin		

Are you aware of being allergic to any other medications or substances?
If yes, list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____

PHONE _____

PATIENT Signature (Parent of Child) _____ Date:_____

DENTIST Signature _____

HEALTHY SMILES OF LAKEWAY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____ Date of Birth:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By either printing and signing this form, or submitting this form electronically, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time on this website or by contacting:

Contact Person: Office Manager
Telephone: 512-263-8989, Fax: 512-263-9095
Address: 2422 RR620 South, Suite A126, Lakeway, TX 78738
Email: healthysmilesatx@gmail.com

Right to Revoke: You have the right to revoke this Consent at any time by sending written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we have taken in reliance on this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke this Consent.

I, _____(**printed**) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE

Signature_____ Date:_____
(parent signature if child under 18)

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

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 14th, 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you *$2.00* for each page, *$25.00* per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Restriction: 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 of 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: Office Manager
Telephone: 512-263-8989, Fax: 512-263-9095
Email: healthysmilesatx@gmail.com
Address: 2422 RR 620 South, Suite A126, Lakeway, TX 78738