

Medical History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you take, or have taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you use controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you have frequent headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you have sensitive teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal
 Latex Local Anesthetics Other _____

Women – Are You:

- Pregnant/Trying to get pregnant?
 Nursing?
 Taking Oral Contraceptives?

- | | | | | |
|-------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxie | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____
Street City State Zip

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

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

Purpose of Consent: By signing this form, you will 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 accompanies this Consent. 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 by contacting:

The Dentist's Studio

Address: 1350 Orange Ave. #106
Winter Park, FL 32789
Phone: 407.647.1744
Fax: 407.647.0139

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had a 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: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT
Include completed Consent in the patient's chart

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____

THE DENTIST'S STUDIO

Dr. Zachary Hodgins
FINANCIAL POLICY

Thank you for choosing our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

About Our Fees

The following is a statement of our financial policy, which we ask you to read and sign prior to any treatment. YOUR CO-PAY & DEDUCTIBLES ARE DUE IN FULL AT THE TIME OF SCHEDULING YOUR APPOINTMENT. To accommodate you, we accept cash, checks, Visa, Mastercard, American Express and Discover. For extensive treatment plans we offer extended payment plans with prior credit approval. Interest will be charged at a monthly rate of 1.5% for accounts that are past due. If your account is sent to our collection agency, you will be responsible for any and all costs involved with the collection process. This will include all court costs or attorney's fees.

Regarding Insurance

We will accept assignment of insurance benefits. However, we do require that your co-payment and deductible be paid in full at the time of your visit. The balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your claims, provided you give us accurate insurance information. We will assist you in completing the necessary forms to process your secondary insurance claims. It is your responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and /or not considered reasonable or necessary under the policy your employer has selected. Please note that if a service is not a covered benefit under your policy the full financial responsibility is yours.

Missed Appointments

Please help us serve you and our other patients better by keeping scheduled appointments. Your appointment time is reserved especially for you. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Missed appointments are charged an appropriate fee. Please consider your calendar carefully when scheduling appointments.

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Any of our staff members would be glad to review the financial policy with you at any time.

I have read the financial policy. I understand and agree to the terms of this policy.

X _____
Signature of Patient or Responsible Party

Date

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
- A communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____