HEALTH HISTORY FORM

Name _____ Date _____

Address_____ Social Security Number_____

_____ _____

Marital Status_____ Date of Birth_____

Email_____ Best phone number to reach you_____

Would you like to be contacted via text or email for confirming appointments and receive the latest updates from our office? Yes or No

Whom may we thank for referring you to our office?_____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Blood Pressure? (Please circle)

Have you ever received a diagnosis of "high blood pressure"?	No	Yes

Are you allergic or have you had a reaction to:

a.	Local anesthetics ……...	No	Yes
b.	Penicillin or other antibiotics ……	No	Yes
c.	Aspirin, Ibuprofen or Tylenol …..……	No	Yes
d.	Codeine, Valium® or other sedatives……	No	Yes
e.	Latex or Metals		
f.	Other (please specify)_____		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

Financial Policy for Payment Of Dental Services

Thank you for choosing Danner Dental as your dental healthcare provider. We are committed to providing you with the proper treatment needed to maintain your dental health. The following is a statement of our financial policy. We ask that you read and sign the policy. If you have any concerns about our payment policy, please do not hesitate to ask.

We understand that finances do play a part of your decision when accepting our suggested treatment, and we are here to make sure that you receive the best care possible. In order to achieve this, we are able to offer you options that would make you happy and comfortable with our services. Please ask your financial coordinator for more information about these options.

As your health care provider, we are committed to satisfy the patient to make their visit to our office a comfortable, gentle and overall a wonderful experience. Your financial coordinator is able to provide the service of submitting, and receiving any payments from your medical/dental insurance company. We strive to make sure that you receive the maximum benefit from your insurance as much as possible. Remember, dental insurance is there to help your wallet, not your decision to cater your mouth to a healthier state. Dental/medical insurance is not a guarantee of payment, therefore, as the patient you are responsible for any deductible, co-pays or other payments that the insurance does not cover.
Danner Dental is currently accepting the following methods of payment: Cash, Check, Credit Card (MasterCard, Visa, Discover, American Express) or Care Credit. **Payment of services rendered are desired at the time of service.**

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form or any of our dental services, please do not hesitate to ask. Signing this form indicates that you fully understand and comply with our financial policy.

PRIMARY INSURANCE
Subscriber:_____ Social Security Number:_____
Occupation:_____ Date of Birth:_____
Insurance Company:_____ Identification Number:_____
Group Number:_____ Customer Service Number:_____

SECONDARY INSURANCE
Subscriber:_____ Social Security Number:_____
Occupation:_____ Date of Birth:_____
Insurance Company:_____ Identification Number:_____
Group Number:_____ Customer Service Number:_____

Signature_____ Date_____

PATIENT AUTHORIZATION FORM-HIPAA

This Authorization sets forth your right to use or disclose my protected health information as specified below for the purposes as designated below:

Description of specific information authorized:

- Call home to leave messages on answering machine regarding:
  account information, treatment, insurance information, pre-medications.
- Who can we leave information with? Name of Person or persons:

  _____
- Can we call you at work? (If yes, what is the number) _____

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your privacy officer.
- Inspect or copy the protected health information to be used or disclosed.
- Refuse to sign this authorization, knowing that you will not condition treatment or payment on me providing this authorization (except for research related treatment).

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Print Patient Name: _____

Signature: _____

Relationship To Patient If Not The Patient: _____

Date: _____

PATIENT CONSENT FORM-HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Signature: _____

Relationship To Patient If Not The Patient: _____

Date: _____

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, out 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 7/12/12 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 the 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 for 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 health care 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 is 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, or 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 this 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 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, as 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 preferred 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 the Notice. We will charge you 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 requested copies, we will charge you $0.10 for each page, $6.00 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 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 July 12, 2012. 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 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 if must explain why the information should be amended). You may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website 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 an 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 a complaint with us or with the U.S. Department of Health and Human Services.