DENTAL HEALTH ASSOCIATES HEALTH FORM

Date: _____

Name: _____ (Last / First / Middle)
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____
Occupation: _____ Employer: _____
Name of spouse: _____
Occupation: _____ Employer: _____

Home Phone: (____)_____
Cell Phone: (____)_____
Business Phone: (____)_____
Date of Birth: ____/____/____ (Month / Date / Year)
S.S.#: ____/____/____
Business Phone: (____)_____
S.S.#: ____/____/____

Dental Insurance Company #1

Dental Insurance Co.: _____ Business Phone: (____)_____
Group #: _____ This dental Insurance is provided through: Insured's Name: _____
Insured's S.S.#: ____/____/____ Insured's Birthdate: ____/____/____ (Month / Date / Year) Insured's Employer: _____

Dental Insurance Company #2

Dental Insurance Co.: _____ Business Phone: (____)_____
Group #: _____ This dental Insurance is provided through: Insured's Name: _____
Insured's S.S.#: ____/____/____ Insured's Birthdate: ____/____/____ (Month / Date / Year) Insured's Employer: _____

In case of emergency, who should we contact other than spouse?
Name: _____ Relationship: _____ Phone: _____

Referred by: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health ..... yes no
2. Has there been any changes in your general health within the past year? ..... yes no
3. My last physical exam was on: ____/____/____
4. Are you now under the care of a physician? ..... yes no
   If so, what is the condition being treated? _____
5. The name and address of your physician(s) is: _____ Phone: (____)_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... yes no
   If so, what was the illness: _____
7. Are you taking any medicine(s) including non-prescription Medicine? ..... yes no
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases?
   a. Damaged heart valves or artificial heart valves, including heart murmur, rheumatic heart disease, rheumatic fever, or mitral valve prolapse? ..... yes no
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... yes no
      1. Do you have chest pain upon exertion? ..... yes no
      2. Are you ever short of breath after mild exercise or when laying down? ..... yes no
      3. Do your ankles swell? ..... yes no
      4. Do you have a cardiac pacemaker? ..... yes no
   c. Allergy ..... yes no
   d. Sinus trouble ..... yes no
   e. Asthma or hay fever ..... yes no
   f. Fainting spells or seizures ..... yes no
   g. Diabetes ..... yes no
   h. Hepatitis, jaundice or liver disease ..... yes no
   i. AIDS or HIV infection ..... yes no
   j. Thyroid problems ..... yes no
   k. Respiratory problems, emphysema, bronchitis, etc ..... yes no
   l. Arthritis, painful swollen joints, or prosthetic joint replacement ..... yes no
   m. Stomach ulcer or hyperacidity ..... yes no

n. Kidney problems or renal dialysis ..... yes no
o. Tuberculosis ..... yes no
p. Persistent cough or cough that produces blood ..... yes no
q. Persistent swollen glands in neck ..... yes no
r. Low blood pressure ..... yes no
s. Sexually transmitted disease ..... yes no
t. Epilepsy or other neurological disease ..... yes no
u. Problems with mental health ..... yes no
v. Cancer ..... yes no

9. Have you had any abnormal bleeding? ..... yes no
   a. Have you ever required a blood transfusion? ..... yes no
10. Do you have any blood disorders such as anemia? ..... yes no
11. Have you ever had any treatment for a tumor or a growth? ..... yes no
12. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... yes no
    b. Penicillin or other antibiotics ..... yes no
    c. Barbiturates, sedatives, or sleeping pills ..... yes no
    d. Aspirin ..... yes no
    e. Codeine or other narcotics ..... yes no
    f. Other ..... yes no
13. Have you had any serious trouble associated with previous dental treatment? ..... yes no
    If so, explain:
14. Do you have any disease, condition, or problem listed above that you think we should know about? ..... yes no
    If so, explain:
15. Are you wearing contact lenses? ..... yes no
16. Are you wearing removal dental appliances? ..... yes no
17. Do you smoke or use any other tobacco products? ..... yes no

Women:

18. Are you pregnant? ..... yes no
19. Are you nursing? ..... yes no
20. Are you taking birth control pills ? ..... yes no

FOR OFFICE USE ONLY- PLEASE DO NOT FILL OUT

Dental History:

1. Chief dental complaint :_____
2. How long has it been since you last visited a dental office?_____ Last x-rays?_____
3. What was done for you at that time?_____
4. Why did you leave your last dentist? _____
5. Do any of your teeth ache, or are any sensitive to heat, cold or pressure? _____
6. Do you grind your teeth or clench your jaw? _____
7. Do you have frequent headaches? _____
8. Are you aware of any sores or growths in your mouth? _____
9. Have you ever had any complications during or following dental treatment? _____
10. How important are your natural teeth to you? 1 2 3 4 5 6 7 8 9 10
    NOT IMPORTANT VERY IMPORTANT
11. How do you feel about your smile? 1 2 3 4 5 6 7 8 9 10
    UNHAPPY HAPPY
12. Are your teeth white enough? ..... yes no
13. Are you concerned about bad breath? ..... yes no
14. Do you snore or have you been diagnosed with sleep apnea? ..... yes no

I certify that I have read and understand the above. I have acknowledge that my question, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for errors or omissions that I have made in completion of this form.

Signature of Patient:_____ Date:_____

Signature of Doctor:_____ Witness: _____

Dental Health Associates

210 W. Airport Hwy. • PO Box 270 • Swanton, Ohio 43558
419-826-2525 • fax: 419-825-5067
swanton.office@dentalha.com • www.itneverhurtstosmile.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health insurance information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means discussing, providing, coordinating, or managing dental care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute non-identifiable health information by removing all reference to your identity such as before and after photographs of treatment procedures.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures such as DHA childrens "No Cavity Club" will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications or protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health insurance.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer."

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
(202) 619-0257 • Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address on the front of this acknowledgment document to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Statement of Responsibility

The patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, we cannot take responsibility for your care.

Patient Initials: _____

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please remember that your insurance policy is a contract between you and your insurance carrier. Co-payments are due at the time of service. Patients without insurance are expected to pay at the time the service is rendered.

Patient or Responsible Party Signature: _____ Date: _____

Assignment of Benefits

I authorize the release of all dental information necessary to process insurance claims on my behalf. I authorize the assignment of benefit payment to which I am entitled to Dental Health Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: _____ Date: _____

Dental Health Associates

210 W. Airport Hwy. • PO Box 270
Swanton, Ohio 43558
419-826-2525
fax: 419-825-5067 • swanton.office@dentalha.com
www.itneverhurtstosmile.com

Date _____

Your Name: _____

Getting to know a little more about you...

Thank you for being a part of our dental family. To get to know you even better, please tell us a few more things about yourself.

What are your favorite hobbies or activities? (circle all that apply)

Golf Reading Hunting/Fishing

Gardening Other: _____

Are there any other special interests, sports, or hobbies that you would like to share with us?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What is your favorite restaurant?

_____