Medical and Dental History

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____City/State: _____ Zip: _____

Home Phone: _____ Cell: _____ Driver's License#: _____

Single:__ Married: __ Separated:__ Divorced:__ Widowed:__ E-mail Address: _____

Employer: _____ Work Phone #: _____ Ext: _____

Address:_____

SS#: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Spouse's Name: _____ Date of Birth: _____

(Guardian if minor)
SS#: _____ Driver's License: _____

Employer: _____ Work Phone #: _____ Ext: _____

Address:_____

Name of your physician: _____ Name of your previous dentist: _____

Referred by: _____ Reason for appointment: _____

Name, address & phone # of nearest relative (not living with you): _____

_____

Insurance Information

Insurance Company_____ Group# _____

Name of Person Insured_____ Relation to Insured_____

***Circle the appropriate answer that applies to you. If in doubt, circle "DNK" for Do Not Know. Please fill in any other information in the provided blank spaces.**

Dental History

1.	How would you describe your dental health?	Excellent	Good	Fair	Poor
2.	Have you ever had orthodontic treatment (braces)?		Yes	No	DNK
3.	Are your teeth sensitive to hot or cold?		Yes	No	DNK
4.	When were your teeth cleaned last? _____				
5.	If known, date of last full mouth dental X-rays: _____				
6.	Have you had previous gum trouble?		Yes	No	DNK
7.	Do you use mints, Lifesavers, hard candies, etc…regularly?		Yes	No	DNK

Problems relating to occlusion "bite" or jaw joint

1.	Are you aware of a tired feeling in your face?	Yes	No	DNK
2.	Do you have a ringing in your ears?	Yes	No	DNK
3.	Do you clench or grind your teeth?	Yes	No	DNK
4.	Do you have frequent headaches?	Yes	No	DNK
5.	Do you have pain around your ears, eyes, head, or neck?	Yes	No	DNK

General Health

1.	Do you have any type of health problem?	Yes	No	DNK
2.	Do you have any type of heart problem?	Yes	No	DNK
3.	Do you have high blood pressure?	Yes	No	DNK
4.	Do you have low blood pressure?	Yes	No	DNK
5.	Do you have shortness of breath after climbing a flight of stairs?	Yes	No	DNK
6.	Do you bleed for more than 30 seconds for a minor cut?	Yes	No	DNK
7.	Are you taking medications? If so, please list: _____			
	_____			
8.	Have you been hospitalized in the last five years?	Yes	No	DNK
	If yes, please explain: _____			
9.	Do you faint easily?	Yes	No	DNK
10.	Have you taken cortisone or steroids in the last six months?	Yes	No	DNK
11.	Have you been under the care of a physician in the last year,			
	Other than a routine physical?	Yes	No	DNK
12.	Have you had a major illness or serious operation in the last five years?	Yes	No	DNK
	If yes, please explain: _____			
13.	Have you had rheumatic fever?	Yes	No	DNK
14.	Do you have any type of artificial joint, heart valve or pacemaker now in place?	Yes	No	DNK
15.	Are you allergic to any medications?	Yes	No	DNK
	Please list: _____			

16. Please estimate the number of cups, glasses, etc. you consume each day on average:

Coffee_____ Tea_____ Soft Drinks_____ Alcoholic Beverages_____

Family History

	Have any members of your family (blood kin) had heart disease,			
	high blood pressure or diabetes? (please circle)	Yes	No	DNK
2.	Do any members of your family snore or have sleep apnea?	Yes	No	DNK

Medical History

1.	Anemia?	Yes	No	DNK
2.	Frequently swollen ankles?	Yes	No	DNK
3.	Stomach ulcers?	Yes	No	DNK
4.	Excessive thirsts or hunger over an extended period of time?	Yes	No	DNK
5.	Change in urination frequency?	Yes	No	DNK
6.	Cuts tend to heal slowly?	Yes	No	DNK
7.	Diabetes?	Yes	No	DNK
8.	Thyroid disturbance or taken thyroid tablets?	Yes	No	DNK
9.	Tuberculosis or emphysema?	Yes	No	DNK
10.	Hepatitis?	Yes	No	DNK
11.	AIDS or AIDS-related complex or positive for the AIDS virus?	Yes	No	DNK

12. Kidney or bladder disease problems?	Yes	No	DNK
13. Arthritis or rheumatism?	Yes	No	DNK
14. Venereal disease (syphilis, gonorrhea, herpes II)?	Yes	No	DNK
15. Epilepsy, convulsions, , or seizures?	Yes	No	DNK
16. Cancer or radiation therapy?	Yes	No	DNK
17. Mitral Valve Prolapse?	Yes	No	DNK
18. Smoke or use tobacco in any form?	Yes	No	DNK
19. Are you taking any anti-depressants or sleep medications?	Yes	No	DNK
If yes, please list: _____			
20. Are you taking any anticoagulants (blood thinners)?	Yes	No	DNK
21. Are you taking antacids regularly?	Yes	No	DNK
22. Glaucoma?	Yes	No	DNK
23. Asthma, hay fever, or eczema?	Yes	No	DNK
24. Liver problems?	Yes	No	DNK
25. Males only: Prostate problems?	Yes	No	DNK
26. Females only: Are you pregnant?	Yes	No	DNK
Are you taking birth control pills or other hormones?	Yes	No	DNK
27. Esophageal Reflux (GERD)?	Yes	No	DNK

Do you have any disease, condition, or problem not listed above that you think we should know or that you believe would affect treatment in any way? _____

_____

_____

Is there anything you would like to change your smile?_____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to select the most appropriate number for each situation.

0= would ***never*** doze **1**= ***slightly*** chance of dozing **2**= ***moderate*** chance of dozing **3**= ***high*** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching Television	_____
Sitting, inactive in a public place (theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

I realize that it is solely my responsibility to inform my dental office of any medical problems, allergies, or changes that occur in my health record from one visit to the next. I hereby certify that all of the information on this form is correct.
By signing this application I agree to be held for all charges and services or charges that are not paid by my insurance company (if applicable), I certify that the information above is true and that if any information is to be found falsified that legal action may be taken.

Patient's Signature: _____ Date: _____

(Guardian if minor

Nourian Dental
6210 Campbell Rd suite 160
Dallas ,Tx ,75248

FINANCE POLICY FOR OUR DENTAL PATIENTS

It is our goal to provide the best possible dental care for you and at the same time avoid any confusion regarding our financial policy. We promise to provide you, in advance of treatment, with the amount of payment that will be required. This way you have the opportunity to discuss treatment alternatives or payment arrangements if finances are a concern.

REGARDING FINANCIAL ASSISTANCE

We do realize that, on occasion, financial circumstances can make payment difficult. If you have a financial concern, we ask that you speak with our financial manager. We accept MasterCard, Visa, American Express and Discover. We have also made it possible for patients to arrange for financial assistance.

REGARDING CANCELLATION OF APPOINTMENT & EMERGENCY CARE

We reserve time for our patients so that we can give the time and attention to each patient that they deserve. We ask that you notify our office 48 hours in advance if circumstances require you to change your appointment. We reserve the right to charge a $35 fee for appointments that are not cancelled or rescheduled 48 hours prior to appointment time. Should you have a dental emergency, please call our office in advance of coming. We will appoint you as quickly as our schedule permits. If your emergency is after hours, simply call our office number and leave a complete message on our answering machine. We will contact you immediately the next business day.

FINANCIAL RESPONSIBILITY AGREEMENT

The agreement for treatment and payment is between the patient and our office. The charges, therefore, are your responsibility. Payments for services are due at the time services are rendered. Please note that when insurance information is verified the benefits quoted by the insurance company are not a guarantee of payment until claims have been received and processed. Therefore there is no way of knowing the exact portion that the insurance company will pay, until after the procedure has been done. The treatment estimate our office provides is a courtesy, and not required of us. In the event of non-payment, the patient agrees to pay all the costs of collection, including but not limited to attorney fees, court costs, collection agency fees, etc. If a check is dishonored or returned for any reason, you agree to cover any return check fees placed on this office. Your usage of a check for payment is your acceptance of this agreement and its terms.

I have read and understood the financial policy of this practice and I agree to its terms. I also understand and agree that such terms may be amended from time to time by the dental practice.

_____

Patient/Responsible Party Signature Date

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operation , treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

Patient's Consent

Name: ____

Address: ______________________________________

City: _____________________________ State: ___________ Zip: ____________________

Telephone: (_________)_________________ Email: _______________________________________

Social Security #____

I, ____, have read your Notice of Privacy Policies and I
(signature)
consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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

Personal Representative's Name: ____

Relationship to Patient: ____

**********************Please Stop Here if you filled out the above information***************************
****

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____________________________________ Date: _____________________________

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

Personal Representative's Name: ____

Relationship to Patient: ____

The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received a copy of Nourian Dental's Notice of Privacy Policies.

_____

Name (print)

_____ _____

Signature Date

OFFICE USE ONLY

On _____, an *Acknowledgment of Receipt of Notice of Privacy Policies* form was delivered. The form was not signed due to:

- ❑ Communication barriers which prevent acknowledgement
- ❑ An emergency which prevent acknowledgement
- ❑ A refusal to sign
- ❑ Other _____