ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐

Nursing? If yes, number of weeks: _____ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

	Yes	No	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5°F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

Form S50021 To reorder call 800.947.4746 or go to ADAcatalog.org.

Taylorsville DENTAL

FINANCIAL POLICY

Please understand that **PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR DENTAL TREATMENT**. Our experience has shown that patients appreciate knowing what their financial responsibilities are before treatment begins. Knowing ahead of time allows you to make arrangements to meet your obligations without being surprised at the end of treatment. Please read & sign this form indicating your understanding of, and agreement to, these terms.

WE ACCEPT: Cash, personal checks, major credit cards, or "Care Credit", a company which offers 6, 12, or 18 month no-interest payment plans and/or low-interest, long-term financing. Please ask for details.

MISSED APPOINTMENTS: Please help us serve all of our patients better by keeping your scheduled appointments. We reserve the right to charge a $50 fee for appointments not cancelled at least 24 hours in advance.

USUAL & CUSTOMARY FEES: Our fees are based on average fees for our area. We participate in an annual fee survey of dentists who practice in the northern Utah area, and find, almost without exception, that our fees are at or below average.

Most dentists have found that insurance companies tell their subscribers that some dental fees are "above the usual and customary (UCR) fees", rather than telling you that the benefits they provide are too low. Some insurance companies do not upgrade their fees often enough, even though the cost of living rises. You are responsible for payment regardless of an insurance company's arbitrary determination of what constitutes "usual & customary" fees.

INSURANCE: We accept assignment of your benefits, which means that the insurance carrier will send payment of their portion of the charges directly to our office. We will prepare the claim forms and assume the cost of mailing them to the insurance carrier. HOWEVER, please understand that your insurance policy is a contract between your employer, or you, and the insurance company. We are not a party to that contract. ***You are responsible for all charges which insurance does not cover.*** The estimated amount of your portion will be explained to you before treatment begins.
No insurance company pays 100% of all fees.

Some services provided may NOT be covered by your insurance policy. Since we deal with many insurance companies, and an even greater number of differing policies offered by these companies, we cannot be responsible for knowing all provisions of all policies. Some policies pay a "fixed amount" per procedure (co-pay); while others pay a "percentage" of the procedure fee (co-insurance). It is your responsibility to understand your policy's deductibles, co-pay and co-insurance amounts, annual maximum benefit amount, as well as the policy's limitations and exclusions.

SECONDARY INSURANCE: Having more than one insurance DOES NOT necessarily mean that dental work will be covered 100%. Secondary insurance pays based on what the primary insurance paid. Some secondary policies have a "non-duplication" clause when coordinating benefits which limits their liability. Please be familiar with your policy's provisions.

CO-PAY / CO-INSURANCE: **Co-pay and co-insurance amounts are due at the time of service, unless previous arrangements have been made.** We will estimate these amounts as closely as possible. If your insurance company pays less than we estimated, we will send you a statement after we receive their payment. "Co-pay" is a fixed dollar amount paid per procedure or visit (such as a regular check-up). "Co-insurance" is the percentage of the charges for basic and major procedures which your policy requires that you pay: for example, 50% on crowns, or 80% on fillings, etc.

MINOR PATIENTS: The adult accompanying a minor child and/or the parent/guardian of the minor child are responsible for full payment regardless of divorce or separation issues. These issues involve the parents, NOT our office.

FINANCE CHARGES AND Interest will be charged at 1-1/2% per month (18% annually) on balances over 60 days, with minimum charge of $1.00.

If it becomes necessary to refer this account to a collection agency, **a fee of 45%** of the principal balance owing will be added to the amount to be collected. **I agree to pay all collection costs and reasonable attorney fees if a suit is filed to collect money owed by me.**

RELEASE OF INFORMATION: I authorize release of financial information concerning my account, including charges, payments, and interest assessed to the dentist's collection agency or collection attorney if any collection procedures described above become necessary.

PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS AND WE WILL DO OUR BEST TO ADDRESS THEM.

I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND AND AGREE TO ABIDE BY THIS POLICY.

_____ _____

Signature of patient or responsible party **Date**

PATIENT INFORMATION

TODAY'S DATE_____

PATIENT NAME_____ DATE OF BIRTH_____

HOME ADDRESS _____ APT. #_____

CITY _____ STATE _____ ZIP CODE_____

TELEPHONE: HOME # _____ SSN # _____

EMAIL _____ EMPLOYER _____

CELL # _____ JOB TITLE _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

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

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: Same person as patient above? YES _____ NO _____

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP CODE_____

TELEPHONE: HOME # _____ SSN # _____

EMAIL _ _____ EMPLOYER _____

CELL # _____

IS THERE DENTAL INSURANCE COVERAGE? YES _____ NO _____ *IF YES, PLEASE COMPLETE NEXT SECTION.*

PRIMARY INSURANCE COVERAGE:

POLICY HOLDER'S NAME _____ ID # OR SSN# _____

POLICY HOLDER'S DATE OF BIRTH _____ RELATIONSHIP TO PATIENT Self ____ Spouse ____ Child _____

INSURANCE COMPANY NAME _____ GROUP # _____

CLAIMS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CUSTOMER SERVICE TELEHPONE # _____

IS PATIENT COVERED BY MORE THAN ONE DENTAL INSURANCE? _____ IF YES, PLEASE COMPLETE NEXT SECTION.

SECONDARY INSURANCE COVERAGE:

POLICY HOLDER'S NAME _____ ID # OR SSN# _____

POLICY HOLDER'S DATE OF BIRTH _____ RELATIONSHIP TO PATIENT Self ____ Spouse ____ Child _____

INSURANCE COMPANY NAME _____ GROUP # _____

CLAIMS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CUSTOMER SERVICE TELEHPONE # _____

Taylorsville DENTAL
1951 West 4700 South, #4
Taylorsville, UT 84129
(801) 966-8921

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this Acknowledgement **

My signature below confirms that I have received a copy of this office's *Notice of Privacy Practices*, which details how my protected health information may be used or disclosed according to the HIPAA Privacy Act of 1996. I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I understand that my dental provider's *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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

Patient name (printed): _____ Date_____

Signature: _____

Relationship to patient: _____

Dependent family members (under age 18) also covered by this acknowledgement:

_____

_____

_____

****

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) _____

NOTICE OF PRIVACY PRACTICES

Taylorsville DENTAL

1951 West 4700 South Suite #4
Taylorsville, UT 84129
(801) 966-8921

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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records & other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you new rights to understand & control how your health information is used. HIPAA provides penalties for entities that misuse personal health information. **We are required by law to maintain the privacy of your protected health information** and to provide you with notice of our legal duties & privacy practices with respect to protected health information. As required by HIPAA, we have prepared this explanation of how we are required by this law to maintain the privacy of your health information, and how we may use & disclose your health information.

Without your specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. For example:

- **Treatment** means providing and/or coordinating health care and related services. We may use or disclose your health information to a physician or other healthcare provider involved in your care.
- **Payment** means obtaining payment for services we provide to you. This may include confirming insurance coverage, and billing or collection activities.
- **Health care operations** include the business aspects of running our dental practice. For example, patient information may be used for training purposes, quality assessment, certification or licensing activities.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other individual to the extent necessary to help with your health care or payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected information necessary to facilitate needed care. We will also use our professional judgment to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home and/or work. We may also disclose your health information when we are required to do so by law, or when reporting suspected abuse, neglect, or domestic violence to appropriate officials. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that written request, except to the extent that we have already taken actions relying on your prior authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below. These rights include:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, personal friends, or any other person identified by you. These requests must be made in writing. 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 request that we communicate with you about your health information by alternative means or at alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled by the alternative means or location you request. These requests must be in writing.
- The right to access, inspect, and copy your health information, with limited exceptions. These requests must be in writing. A form to request access can be obtained by contacting our office at the address listed at the bottom of this form. A reasonable fee may be assessed for copying the information.
- The right to request an amendment to 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.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

This notice is effective as of October 1, 2005, 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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against your for filing a complaint.

For more information about our Privacy Practices, please contact:
Taylorsville Dental
1951 West 4700 South, #4
Taylorsville, UT 84129
(801) 966-8921

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Service Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(877) 696-6775 (toll-free)