HODIAH
DENTAL CARE

Patient Information

Name _____ (□Male / □Female)

Date of Birth (mm/dd/yy) ____ / _____ / _____ □ Married □Single □Divorced □Widowed □Partner

Address _____
Street Apartment# City State Zip code

Phone No. • Home _____ • Cell _____ • Work _____

Email _____ May we contact you by email? □Yes □ No

Emergency Contact _____ Phone _____

How did you hear about us? □Newspaper □TV □Radio □Internet □Referral □Other: _____

Dental Insurance Information

Subscriber Name _____ Relationship _____

Employer Name _____ Employer Phone _____

Insurance Company _____ Insurance Phone _____

Insurance ID No. _____ Insurance Group No. _____

Do you have additional insurance? □Yes □No

Subscriber Name _____ Relationship _____

Employer Name _____ Employer Phone _____

Insurance Company _____ Insurance Phone _____

Insurance ID No. _____ Insurance Group No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Please answer the following medical history questions as correctly as possible.

Are you currently under the care of a physician? □Yes □No

Physician name _____ Phone _____

Have you ever had or currently have any of the following? Please check all that apply.

- ❑ Abscess
- ❑ Allergies to drugs
- ❑ Allergies to anesthetics
- ❑ Anemia
- ❑ Artificial joints
- ❑ Arthritis, Rheumatism
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Epilepsy/ Seizures
- ❑ Eye disorder
- ❑ Fainting
- ❑ Fay fever
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head injuries
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Hemophilia
- ❑ Hepatitis (DB/ De)
- ❑ Hernia repair
- ❑ High / Low blood pressure
- ❑ HIV infection
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mental disorders
- ❑ Neurological problems
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pregnancy Month___
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Stomach problems
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/ Colitis
- ❑ Venereal disease
- ❑ Other

Are you allergic to:
□ Aspirin □ Codeine □ Latex (rubber) □ Local Anesthetics □ Narcotics □Penicillin □Sulfa Drugs □ Other

Do you have any conditions that are not listed above that we should know about?

_____

List medications you are currently taking and the correlating diagnosis:

_____

List all complications or allergic reactions if you have or have had any.

_____

Has your doctor told you to take antibiotic medication before dental treatment? □Yes □ No
Do you take a bone-building drug? □Yes □No
Are you nursing? □Yes □ No Are you taking oral contraceptive? □Yes □No

X-rays can cause fetal development problems and some antibiotics can affect birth control efficiency. Initial __

_____ Date _____
Signature of patient / parent or guardian

Dental History

Have you ever had or currently have any of the following? Please check all that apply.

- ❑ Abnormal bleeding after dental care
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Brushing Frequency: _____
- ❑ Clenching or grinding
- ❑ Clicking or popping jaw
- ❑ Cough up blood
- ❑ Cold/ Canker sores or blisters
- ❑ Complication from extraction
- ❑ Dental Floss Frequency: _____
- ❑ Disclosing tablets or solution
- ❑ Dry mouth
- ❑ Fluoride supplements
- ❑ Food impaction
- ❑ Frequent snacking
- ❑ Gag easily
- ❑ Jaw pain
- ❑ Loose or broken fillings/ teeth
- ❑ Mouth breathing
- ❑ Oral habits, i.e. suck thumb
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Receding gums
- ❑ Sensitive/ sore gums
- ❑ Sensitive to hot/ cold
- ❑ Sensitive to pressure
- ❑ Sensitive to sweets
- ❑ Swelling or lumps in mouth
- ❑ Texture of tooth brushing _____
- ❑ Tobacco habit/ smoking
- ❑ Toothaches
- ❑ Unfavorable dental experience
- ❑ Unpleasant taste
- ❑ Unusual sounds in ear while eating
- ❑ Water jet device
- ❑ Other

Any previous dental treatments? □Yes □No If Yes, when & what _____

Chief oral complaint _____

Reason for today's visit _____ Date of last dental visit _____

Additional interest in □ Whitening □ Bonding □ Veneers □ Crowns □ Invisalign □ Night guard

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date _____

Signature of patient / parent or guardian

Authorization

I authorize the disclosure of information from my treatment records to:

Name of Recipient _____ Relationship _____

I give authorization to disclose the following information:

□ All treatment information □ Specific Date: _____ ~ _____

I understand that I may withdraw or revoke my permission at any time with written words.

_____ Date _____

Printed name & signature of patient / parent or legal guardian

OFFICE FINANCIAL POLICY

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits to be paid directly to Hodiah Dental Care and I understand that I am responsible for the payment of deductibles, copayment, and any balances not covered by my insurance. I further understand that fees for professional services rendered are payable in full within 30 days. A service charge of 1% per month will be added to all account balances for 60 days old, this is an annual rate of 12%. I understand that if my account becomes delinquent, I may be referred to a third party for collection. If this should be turned over to collections, there will be a $75 processing fee applied to the balance. I also understand that future dental services may be limited for all persons under my account until my account is current. I also authorize Hodiah Dental Care to release any information required to process my claims. I understand that payment is due at the time of service. All confirmed appointments that are NOT cancelled within 24 hours of the appointment time will be charged a $99.00 late cancellation fee. All confirmed appointments that are a no show will be charged a $99.00 absent fee.

I have read and agree to the terms in this OFFICE FINANCIAL POLICY.

_____ Date _____

Signature of patient/ parent or guardian

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 INFORMATIONS. PLEASE REVIEW IT CAREFULLY.
THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve of.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with your health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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, and payment for healthcare operations. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.
Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
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. If you request copies, we will charge you a reasonable fee to locate and copy your information and postage if you want the copies mailed to you.

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 decisions 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 at alternative locations, you may complain to us using the contract 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 your complaint with the US Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.
A Privacy/ Contract Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/ Contract Officer.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

_____ Date _____
Signature of patient / parent or guardian

I_____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES as
(Print Name of Patient)
required by federal law and I consent to the use and disclosure of my personal health information by your office during Treatment, Billing/ Payment and Healthcare Operations as outlined in the Notice of Privacy Practices.