Health History

Patient Name:_____

Answer all questions by circling Yes (Y) or No (N) ***(All responses are kept confidential)***

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics or Sulfa Drugs? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers (Valium, etc.) ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin, calcium blockers, procardia or other heart medicine? ..... Y N
   - I. Thyroid Medications? ..... Y N
   - J. Antihistamines or other decongestants (seldane, etc.)..... Y N
   - K. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - L. Any other medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin, Amoxicillin, or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Food products? ..... Y N
   - H. Other allergies or reactions? Please list ..... Y N

_____

_____

9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Have you ever had a bone density scan? ..... Y N
15. Do you have any other disease, condition or problem that you think the doctor should know about? _____

_____

16. Do you wish to talk to the doctor privately about anything? ..Y N
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.
    - D. Are you taking hormone replacements? ……..…Y N

I understand the importance of a truthful and complete Health History to assist my provider in providing the best care possible. I have had the opportunity to discuss my Health History with my provider.

_____ _____ _____

Date | Signature of Person Completing Health History | Doctor's Initials

Reviewed: _____ Date:_____
Reviewed: _____ Date:_____
Reviewed: _____ Date:_____

CHARLES SCHULTZ D.D.S., O.M.F.S.

SOUTHEAST DENTAL GROUP

Welcome to our office. To help us meet your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask! We're happy to help. All information is confidential.

PATIENT INFORMATION

Patient's Name:_____ Today's Date_____

Sex: M / F Birth Date: _____ Soc. Sec. # _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____Cell Phone:_____ Work Phone:_____

Email:_____

Referring Dentist:_____Physician:_____

*** If patient is under 18 or unable to personally make medical decisions, please list all names of legal guardians below**:

_____ Relationship to Patient: _____
_____ Relationship to Patient: _____

Please complete information below.

RESPONSIBLE PARTY

Responsible Party's Name:_____

Soc. Sec.:_____ Home Phone:_____Cell Phone:_____ Work Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Employer:_____ Occupation:_____

INSURANCE INFORMATION *(please present a copy of insurance card to be scanned)*

Primary Dental Insurance
Name of Family Member who carries the policy_____ Birth date_____

Insurance Company:_____

Group Number:_____ Identification Number:_____

Secondary Dental Insurance
Name of Family Member who carries the policy_____ Birth date_____

Insurance Company:_____

Group Number:_____ Identification Number:_____

Family members who have been patients here:_____

Our Office Policy *(all patients must read, initial and sign)*

DENTAL INSURANCE

_____ As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge. However, in order to avoid misunderstandings, please carefully read the following policy in regards to dental benefits.

_____ Our professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment of treatment. However, to serve and assist you in utilizing your dental insurance, this office accepts assignment of your benefits. It is your responsibility to complete necessary paperwork to assign payment to this office, and **you are responsible for balances not covered by your policy on the day of service**. Our office accepts cash, personal checks, credit cards, Care Credit and Lending Club. There is a $25.00 returned check fee due and payable from you for each check payment returned to us by your bank.

_____ Please understand that the amount to be paid by your particular policy is predetermined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan or treatments your plan will cover, you should refer these questions to your employer. At your request, this office will provide all pertinent information to your insurance company, and we will do our best to help you derive the maximum benefits available. However, **we are not responsible for determining what those benefits are to be.**

_____ **If your insurance has not paid on your claim in 90 days, the balance becomes your full responsibility.**

_____ I hereby assign all dental, medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Southeast Dental Group P.C. for treatment they have provided. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the assignee to release all information necessary to secure the payment.

CANCELLED, MISSED APPOINTMENTS, OR LATE ARRIVALS

_____ Our goal is to provide high quality care for our patients. In fairness to other patients and the doctor, we require at least 24 hours notice when canceling an appointment. We reserve the right to apply a $50 no show fee for missed appointments. Following 2 missed appointments, we may only be able to schedule on a wait list basis. The practice reserves the right to dismiss patients with excessive cancelled appointments. Late arrivals for an appointment will result in our inability to see subsequent patients on time. Therefore, any patients arriving 15 minutes late will be rescheduled.

AUTHORIZATION AND RELEASE

_____ I consent to the practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

_____ I authorize my dentist/oral surgeon and his/her staff, to perform an oral examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information and photos acquired in the course of my examination and treatment. I certify that I have read and understand the above information, and all questions have been answered accurately. **I have received a copy of this office's Notice of Privacy Practices.**

_____ _____

Signature of Patient (or parent if patient is a minor)

Notice of Privacy Practices

Southeast Dental Group, PC

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.

I. Dental Practice Covered by this Notice: This Notice describes the privacy practices of Southeast Dental Group. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. Our Promise to You and Our Legal Obligations: The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to: Maintain the privacy of your protected health information; give you this Notice of our legal duties and privacy practices with respect to that information; and abide by the terms of our Notice that is currently in effect.

III. Last Revision Date: This Notice was last revised on June 8, 2016.

IV. How We May Use or Disclose Your Health Information: The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

V. Your Written Authorization for Any Other Use or Disclosure of Your Health Information: Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VI. Your Rights with Respect to Your Health Information: You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review : You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure: You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations: You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach: We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

VIII. Our Right to Change Our Privacy Practices and This Notice: We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is June 8, 2016.

IX. How to Make Privacy Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official: Lena Merrell, Southeast Dental Group, Address: 2220 Dunn Street, Juneau Alaska 99801 phone: (907) 586-9586 Fax: (907) 586-9484

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

YOU MAY KEEP THIS FORM FOR YOUR RECORDS, OR RETURN TO THE FRONT DESK