

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? Yes No

MEDICAL HISTORY

1. Are you in good health? Yes No
2. Have you lost or gained more than 10lb in the past year? Yes No
3. Date of last physical examination? _____
4. Have you ever taken Fen-Phen, Redux, or Pondimin? Yes No
5. Are you now under the care of a physician Yes No
If so, what is the condition being treated? _____
6. Have you ever had any serious illness or operation? Yes No
If so, what illness or operation? _____
7. Have you ever been hospitalized? Yes No
If so, what was the problem? _____
8. Are you taking any medication? Yes No
If so, what? _____ What dosage? _____
9. Are you using any recreational drugs (marijuana, cocaine, etc.)? Yes No If so, what? _____
10. Have you ever been pre-medicated with antibiotics for your dental treatment? Yes No
11. Are you sensitive or allergic to any drugs? Penicillin; Tetracycline; Sulfa Drugs; Aspirin; Codeine; Other Yes No
If Other, what drugs? _____

12. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

- | | | | | | |
|---|--|--|---|--|---|
| Y N Anemia
Y N Herpes
Y N Stroke
Y N Ulcers
Y N Diabetes
Y N Glaucoma
Y N Arthritis
Y N Latex Allergy
Y N Tonsillitis
Y N Asthma
Y N Gerd/Reflux | Y N Hemophilia
Y N Cold Sores
Y N Emphysema
Y N Rheumatism
Y N Chicken Pox
Y N Bruise Easily
Y N Head Injuries
Y N Heart Failure
Y N Scarlet Fever
Y N Sinus Trouble
Y N Persistent Fever | Y N Heart Murmur
Y N Liver Disease
Y N Blood Disease
Y N Drug Addiction
Y N Kidney Disease
Y N Stomach Ulcers
Y N Angina Pectoris
Y N Mental Disorder
Y N Cerebral Palsy
Y N Thyroid Disease
Y N Night Sweats | Y N Tuberculosis (T.B.)
Y N Rheumatic Fever
Y N Blood Transfusion
Y N Joint Replacement
Y N Nervous Disorders
Y N Tumors or Growths
Y N Allergies or Hives
Y N Pain in Jaw Joints
Y N Artificial Prosthesis
Y N Sickle Cell Disease
Y N Persistent Cough | Y N Cortisone Medicine
Y N Allergies to Metals
Y N Excessive Bleeding
Y N High Blood Pressure
Y N HIV Related Complex
Y N Respiratory Disease
Y N Epilepsy or Seizures
Y N Psychiatric Treatment
Y N Hepatitis or Jaundice
Y N Difficulty in Swallowing
Y N Blood in Sputum | Y N Heart Ailments or Attack
Y N Prolapse Heart Valve
Y N Congenital Heart Lesions
Y N X-Ray or Cobalt Treatment
Y N Fainting Spells
Y N Chemotherapy (Cancer, Leukemia)
Y N Radiation Treatment of any kind
Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N TMJ (Temporomandibular Joint) Disorder
Y N Other: |
|---|--|--|---|--|---|

13. Do you wear a cardiac pacemaker, or have you had heart surgery? Yes No
14. Do you have any disease, condition or problem not listed that you think we should know about? Yes No
If so, what? _____
15. Do you smoke? If yes, how much _____ Cigarettes Cigars Packs per day Yes No
16. (Women) Are you pregnant? If so, how many months? Yes No
17. (Women) Do you have any problems associated with your menstrual period? Yes No
18. (Women) Do you take birth control pills? Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
3. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain? _____
4. How long since your last full mouth X-Rays? ___ Weeks ___ Months ___ Years
5. How long since your last dental treatment? ___ Weeks ___ Months ___ Years
6. Does dental treatment make you nervous? Slightly Moderately Extremely? Yes No
7. Would you desire to be pre-sedated? Yes No

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

A Date _____ Signature _____

D Date _____ Signature _____

Changes in health since last visit (If no change, please write 'None')

B Date _____ Signature _____

E Date _____ Signature _____

Changes in health since last visit (If no change, please write 'None')

Changes in health since last visit (If no change, please write 'None')

C Date _____ Signature _____

F Date _____ Signature _____

Changes in health since last visit (If no change, please write 'None')

Changes in health since last visit (If no change, please write 'None')

Health Questionnaire MUST be continually updated!

CONSENT FOR TREATMENT:

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedative, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Signed: _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date _____

Patient's Name _____ **Age** _____ Patient's Birthday _____ Male Female
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ For how long? _____ Own Rent
STREET CITY ZIP

Patient is: Married Single Divorced Separated Widowed Minor Patient SS# _____

Responsible Party Name _____ **Driver's License No.** _____ Res. Phone () _____

Social Security No. _____ Occupation _____ Cell Phone () _____

Employed by _____ How Long? _____ Bus. Phone () _____

Business Address _____ Soc. Sec. No. () _____
STREET CITY ZIP

Spouse's Name _____ **Driver's License No.** _____ Occupation _____

Employed by _____ How Long? _____ Bus. Phone () _____

Business Address _____ Relationship _____
STREET CITY ZIP

Emergency Contact (nonresident) _____ **Relationship** _____ Day time Phone () _____

Complete Address _____ Home Phone () _____
STREET CITY ZIP

Name of Physician _____ () _____

Former Dentist _____ ADDRESS CITY ZIP TELEPHONE () _____

Why are you changing dentists? _____ ADDRESS CITY ZIP TELEPHONE _____

Purpose of Appointment _____

Is this office visit for Emergency Dental Care? Yes No If yes, explain: _____

Who may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ () _____ TELEPHONE
STREET CITY ZIP

PREFERENCE OF PAYMENT: Check Cash Visa/Mastercard

Name of dental insurance company (primary insurance) _____

SUBSCRIBER NAME	BIRTYDAY	RELATIONSHIP	SOCIAL SECURITY NO.
NAME OF GROUP DENTAL PLAN	GROUP NO.	PLAN NO.	NAME OF UNION LOCAL

Name of dental insurance company (primary insurance) _____

SUBSCRIBER NAME	BIRTYDAY	RELATIONSHIP	SOCIAL SECURITY NO.
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TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office can not render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patients examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing of credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or conditions hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss related to this form.

I have read the above conditions of treatment and agree to their content.

Signed _____ Date _____

(OVER)



400 W. Ventura Blvd. #165
Camarillo, California 93010
(805) 482-1558
Fax: (805) 484-8240

The Dental office of Paul Peterson D.D.S., Inc and Associates

Notice of Privacy Practices, effective April 14, 2003

This notice describes how your medical information may be used, disclosed and how you may gain access to this information. Please review it carefully.

General Information: Dr. Paul Peterson and his staff are committed to maintaining the confidentiality of your Protected Health Information (PHI). A new Federal law requires us to provide patients with a summary of our privacy practices and related legal duties, and your rights in connections with the use and disclosure of your PHI.

What is protected: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires Dr. Paul Peterson to have a special policy for safeguarding PHI received or created in the course of providing dental services to you through this office. Your prescriptions, lab tests and information you provided on the patients health history forms are examples of PHI.

Uses and Disclosures of PHI

- We use your PHI to provide you with safe dental treatment in light of your overall health. We may need to provide information to a Pharmacist or a Dental Laboratory to facilitate treatment.
- We may need to discuss your treatment with other Physicians and/or Dentists, with the possibility of referrals to various specialists depending on the conditions being treated.
- We may disclose your PHI to obtain payment for services (i.e.: from insurance providers).
- PHI may be disclosed in connections with healthcare operations, such as accreditation, certification licensing, or reviewing the competence or qualification of Healthcare Providers, as well as for fraud and abuse detection and prevention purposes.
- PHI may be shared with a family member, friends or another person involved in your health care if you do not object to sharing the PHI in the event of an emergency.
- PHI may be needed to identify a workers compensations claim, as provided with in the federal State and Local Laws.
- We may need to allow a Coroner, or Medical Examiner to identify you, or determine your cause of death using PHI. In addition, PHI may need to be shared by Military Command Authorities if you are or were a member of Armed Forces.
- We may use or disclose your health information (i.e.: recall/ maintenance reminder), in a discreet fashion, to provide you with appointment reminders, such as voicemail messages, postcards, or letters.

Your Rights as a Patient

- The patient has the right to access his health information, including copies of x-rays, within the statutes of California State Law.
- The patients has a right to restrict the way PHI is provided to other staff, family members or other persons form whom the patients would like certain information to be kept confidential.
- The patient has the right to receive an accounting of disclosures of PHI. If this accounting is requested more than once in a 12 monthly period, a reasonable fee can be charged for such requests
- The patient has a right to amend his/her PHI.
- The patient has the right to file a complaint to Dr. Paul Peterson, his staff or with the United States Department of Health and Human Services. We take our Complaints Seriously.

Acknowledgement: When first delivering this notice to you, Dr. Paul Peterson will ask that you please sign acknowledgement that you were provided a copy of this **NOTICE**.



AUTHORIZATION OF PROTECTED HEALTH INFORMATION

I _____, hereby authorize withdraw permission to
Name of patient if a minor

Peterson Center for Dentistry to disclose the following health information

- Treatment information
- Financial information
- Insurance information
- Medical Health information
- Dental Records

To Parent _____ Spouse _____ Other _____

This authorization will remain in effect until further notice by name listed above or patient/legal guardian if patient is a minor.

I understand that by signing this authorization:

- I have the right to withdraw permission for the release of my information. This revocation must be made in writing and will affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law

Signature Patient/Parent or Legal Guardian

Date

Signature of witness

Date



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgment

I, _____ have received a copy of this office's
Self or Patient name if a minor

Notice of Privacy Practices.

Please Print Name Self or Parent /Legal guardian if patient is a minor

Signature Parent or Legal Guardian if patient is a minor

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices,
but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other _____

ACKNOWLEDGEMENT OF MATERIALS FACT SHEET

I have received a copy of the Dental Materials Fact Sheet as required by Law.

Signature _____ Date _____
Self or Parent if patient is a minor