Health History Form

ADA.
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last / First / Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____

Mark C Svore DDS PS
2611 Ne 125th Suite 110
Seattle, Wa 98125

INSURANCE INFORMATION

Primary Ins:

Primary Insurance Holder: _____

Relation to Patient _____ Birthdate _____

SS# _____ Employer _____

Insurance Co _____

Group # _____ ID # _____

Address _____

Electronic Payer ID # _____

Additional Ins (Secondary Coverage):

Primary Insurance Holder: _____

Relation to Patient _____ Birthdate _____

SS# _____ Employer _____

Insurance Co _____

Group # _____ ID # _____

Address _____

Electronic Payer ID # _____

Mark C Svore D.D.S.
2611 NE 125th Suite #110
Seattle, WA 98125

NOTICE OF PRIVACY PRACTICES

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.

Our dental office respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment and Health Operations.

For treatment:
Information obtained by a nurse, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including: 1) Medical quality review by your health plan. 2) Accounting, legal, risk management and insurance services. 3) Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of our office. The protected health information in it, however, generally belongs to you. You have the right to:

- Receive, read and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for protected health information.
- Request that you be allowed to see and attain a copy of your protected health information. (We have a form available for this type of request).
- Have us review a denial of access to your health information, except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge every 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not effect information that has already been released. It also does not effect any action taken before we have received it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

- Keep your protected health information private.
- Give you this notice.
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain:
If you have any questions, want more information or want to report a problem about the handling of your protected health information, you may contact our office manager, Betsey (206) 363-3240.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our office manager, Betsey at our office address: *2611 NE 125th, Suite #110, Seattle, WA 98125*. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Notification of Family and Others:
Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends of your condition and that you are in the hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

We may use and disclose your protected health information without your authorization as follows:

- *With medical researchers* – if any research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- *To funeral directors/coroners* – consistent with applicable law to allow them to carry out their duties.
- *To organ procurement organization (tissue donation and transplant)* or persons who obtain, store or transport organs.
- *To the Food and Drug Administration (FDA)* – relating to problems with food, supplements and products.
- *To comply with workers compensation laws* – if you make a workers compensation claim.
- *For public health and safety purposes allowed or required by law* – to prevent or reduce a serious, immediate threat to the health or safety of a person or the public, to protect public health & safety, to prevent or control disease/injury/disability or to report vital statistics such as births or deaths.
- *To report suspected abuse or neglect* to public authorities.
- *To correctional institutions* – if you are in jail or prison.
- *For law enforcement purposes* – such as when we receive a subpoena, court order or other legal process or you are the victim of a crime.
- *For health and safety oversight activities* – For example, we may share health information with the Department of Health.
- *For disaster relief purposes.*
- *For work-related conditions that could affect employee health* – an employer may ask us to assess health risks on a job site.
- *To the military authorities of U.S. and foreign military personnel* – the law may require us to provide information necessary to a military mission.
- *In the course of judicial/administrative proceedings* – at your request or as directed by a subpoena or court order.
- *For specialized government functions* – we may share information for national security purposes.

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: April 15, 2003

Mark C Svore D.D.S.
2611 NE 125th Suite #110
Seattle, WA 98125

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager Betsey (206) 363-3240.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

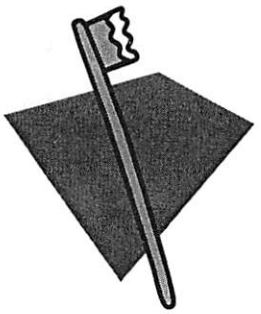
By my signature below I acknowledge receipt of the Notice of Privacy Practices. This form will be retained in your medical record.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Print names of dependents under 18 years old. Relationship to patient



Mark C Svore DDS PS

Lake City Professional Center

FINANCIAL POLICY

We are pleased to offer you the following payment option:

- ❖ CASH OR PERSONAL CHECK
- ❖ PERSONAL CREDIT AND DEBIT CARDS
  - VISA
  - MasterCard
  - Discover
- ❖ FINANCING OPTIONS
  - Dental Fee Plan

Please ask our administrative staff for details

Patient/quarantor agrees to and understands the following:

- ❑ Payment is due at the time of service.
- ❑ As service to our patients, we will contact your insurance carrier for your dental benefits. However, **we are not responsible for any incorrect or incomplete information.**
- ❑ The office will submit up to two times; further insurance appeal becomes the responsibility of the patient/guarantor.
- ❑ Patient/guarantor is responsible to pay at the time of service. If treatment is covered by insurance, a deposit is required by the patient/guarantor.
- ❑ Patient is responsible to pay all charges not covered by insurance, including any fees considered above their insurance carrier's usual and customary fee schedule.
- ❑ Patient/guarantor is responsible for balances in full after 60 days regardless of expected insurance or third party payment.
- ❑ One percent (1%) per month interest (12% per year) will be charged on accounts 90 days past due.
- ❑ Patient/guarantor authorizes their insurance benefits to be paid directly to the doctor.
- ❑ Patient/Guarantor authorizes the doctor or insurance company to release any information required for any claim.

**We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.*

Signature (Responsible Party) Date

2611 NE 125th Suite 110 • Seattle, WA 98125 • Phone: (206) 363-3240 • Fax: (206) 361-4869