

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last physical \_\_\_\_\_

**Place a mark on "yes" or "no" to**

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head/neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Popping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limited Opening	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congested Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ringling Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Posture Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bell's palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	*including plates, screws, and rods	
		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you use tobacco products?

Yes No If yes, what and how often, how long

Do you use antidepressants or sleeping pills?

Yes No if yes, list name(s)

**Do you or your Spouse have the following?**

Sleep Apnea Yes No Do you Snore Yes No

Have you had sleep studies Yes No

(C Pap) Yes No Do you use your CPAP Yes No

Are you on any blood thinners, including aspirin?

Yes mg \_\_\_\_\_ No

Have you ever seen an ENT (ear, nose and throat doctor)?

Yes No Name: \_\_\_\_\_

Have you seen a chiropractor?

Yes No Name: \_\_\_\_\_

Have you seen a neurologist?

Yes No Name: \_\_\_\_\_

Have you had braces?

Yes No Name: \_\_\_\_\_

Do you have massage therapy regularly?

Yes No Name: \_\_\_\_\_

Are you pregnant? Yes No

No If yes when is your due date? \_\_\_\_\_

Taking birth control pills? Yes No

Are you taking hormones? Yes No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis \_\_\_\_\_

Vitamins/Minerals Herbs

Pharmacy Name \_\_\_\_\_

## ALLERGIES

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         |   |
| <input type="checkbox"/> None                          |   |



Our office offers a diverse array of dental services. To help us better understand your needs and desires please check which of the following services in which you are interested.

**Cosmetic Services**

- Smile Makeover
- Porcelain Veneers
- Full Mouth Rejuvenation
- Non-Surgical Facelift Dentistry
- Replacing Old Fillings
- Cosmetic Dentures
- Teeth Whitening

**Examination Services**

- Comprehensive Examination
- Personalized Lifetime Dental Plan
- Teeth Cleaning & Maintenance

**Discomfort / Pain**

- Tooth Pain Relief
- Jaw Pain Relief
- Chronic Headache Treatment
- Migraine Treatment

**Consultative Services**

Consultation about: \_\_\_\_\_

2<sup>nd</sup> Opinion about: \_\_\_\_\_

**Specialized Services**

- Sedation Dentistry
- Dental Implant

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## PATIENT INFORMATION

Date \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 Wished to be called \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Married  Widowed  Single  
 Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 \_\_\_\_\_  
 Employer Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 How did you hear about our office?  
 \_\_\_\_\_

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## INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_

Is there any additional dental insurance? \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Is Patient covered by medical insurance? \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I understand that Aesthetic Dental Creations does not participate with all insurance companies, but will accept the payment from my insurance company towards the dental services that are needed to obtain a healthy mouth.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

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## CONTACT INFORMATION

Home ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_  
 Used for confirming appointments

Work ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_  
 Used for confirming appointments

### IN CASE OF AN EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_

Telephone: \_\_\_\_\_

**SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: **Dr. Balaji**  
**Aesthetic Dental Creations**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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 INFORMATION.  
PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03. And will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective on all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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## USES AND DISCLOSURES OF HEALTH INFORMATION

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

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provided to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provides performance conducting training programs, accreditation certification licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except to those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member or your personal representative or another person responsible for your care of your location your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up, filled prescriptions medical supplies, x-rays or other similar forms of health information.

**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.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstance.

**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 you may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$5.00 for each page per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you if you request an alternative format we will charge a cost based fee for providing your health information in that format if you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment payment healthcare operations and certain other activities for the last 6 years but not before April 14 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost based fee for responding to these additional request.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend 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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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## **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 a decision 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 contact 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 U.S. 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 or with the U.S. department of Health and Human Services.