

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	Ringings 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		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		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

(CPAP) 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

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 | |



Cedar Street Family Dentistry is like no other dental office. This could be the most important dental visit you will ever have.

We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability.....thank you!

- What is the main purpose of your first visit and what would you like to get accomplished? _____

- Briefly mention any positive or negative aspects of your previous dental visits: _____

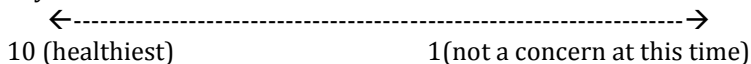
- What do you already know about our office and what are your expectations? _____

Treatment Recommendations or Treatment Options?

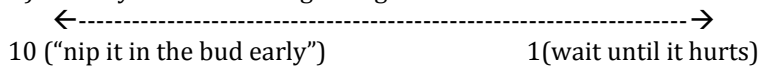
Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you..... please rate on the following scale from 10 to 1.

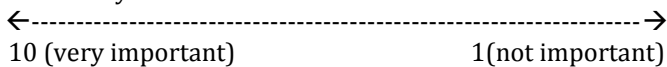
- 1. How (dental) healthy would you like to be?



- 2. Almost all dental problems are predictable and preventable....in order to not overwhelm you with excess details, How preventive (or proactive) would you like to be regarding dental disease?

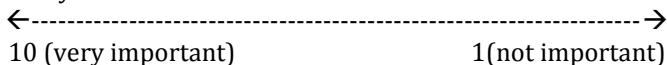


- 3. How important are dental cosmetics to you?



Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.

How important is facial cosmetics to you?



Anything else you would like to mention? _____



NEW PATIENT MENU OF SERVICES

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
- 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: _____

2nd Opinion about: _____

Specialized Services

- Sedation Dentistry
- Dental Implant
- Myofunctional Therapy
(Oral Habit Therapy)

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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 # _____
 ID# _____

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

ASSIGNMENT AND RELEASE

I understand that Cedar Street Family Dentistry participates with multiple dental insurance companies and 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. Cedar Street Family Dentistry 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 () _____
 Work () _____

Cell Phone () _____
Used for confirming appointments
 E-mail Address _____
Used for confirming appointments

IN CASE OF AN EMERGENCY

Name _____ Relationship _____
 Home () _____ Work Phone () _____ Cell Phone () _____



7 CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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: **Michelle Carnes**
Cedar Street Family Dentistry

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: _____