Patient Name:_____ Date: _____

HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of last physical _____

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

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

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ None
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____

2 DENTAL INTERVIEW

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?

←----------→

10 (healthiest) 1(not a concern at this time)

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?

←----------→

10 ("nip it in the bud early") 1(wait until it hurts)

3. How important are dental cosmetics to you*?*

←----------→

10 (very important) 1(not important)

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?

←----------→

10 (very important) 1(not important)

Anything else you would like to mention? _____

3 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
- ❑ Non-Surgical Facelift Dentistry
- ❑ Replacing Old Fillings
- ❑ Cosmetic Dentures
- ❑ Teeth Whitening

Discomfort / Pain

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

Specialized Services

- ❑ Sedation Dentistry
- ❑ Dental Implant
- ❑ Myofunctional Therapy (Oral Habit Therapy)
- ❑ Custom Facelift Dentures

Examination Services

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

Consultative Services

Consultation about: _____

2nd Opinion about: _____

4 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?

_____

5 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#_____

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

6 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 lo 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: _____

REVOCATION 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: _____