MEDICAL AND DENTAL HISTORY FORM

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that benefits your overall health and well-being.

Within the past year, have there been any changes in your general health?

Yes ____ No ____

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name and address: _____

Please mark any of the following to indicate YES in response to the question:

____ Have you ever taken pre-med prior to dental visits?

____ Are you currently under the care of a physician due to a specific condition?

____ Have you been hospitalized within the last 5 years due to a surgery or illness? Please specify.

____ Are you currently taking any prescription or non-prescription drugs? Please specify.

____ Do you use tobacco (smoking or chewing)?

____ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

____ Do you have dental anxiety?

If any of the previous questions are marked, please explain:

_____

WOMEN ONLY: Are you pregnant or nursing?

Yes ____ No ____

Please indicate if you have experienced any of the following:

____ Allergies	____ Anemia	____ Arthritis
____ Artificial Joints	____ Asthma	____ Back Problems
____ Birth Control Pills	____ Blood Disease	____ Blood Thinner
____ Breast Implants	____ Cancer	____ Chemotherapy
____ Codeine Allergy	____ Cough, Persistant	____ Diabetes
____ Dizziness	____ Epilepsy	____ Excessive Bleeding
____ Fainting	____ Glaucoma	____ Hay Fever
____ Head Injuries	____ Headaches, Migraines	____ Heart Murmur
____ Heart Problems	____ Hepatitis	____ High Blood Pressure
____ HIV/AIDS	____ Jaundice	____ JAW PAIN
____ Kidney Disease	____ LATEX Allergy	____ Liver Disease
____ Mental Disorders	____ Mitral Valve Prolapse	____ Nervous Disorder
____ Pacemaker	____ Penicillin Allergy	____ PRE-MED
____ Radiation Treatment	____ Respiratory Problems	____ Rheumatism
____ Seasonal Allergies	____ Siezures	____ Sinus Problems
____ Skin Rash	____ Stomach Problems	____ Stroke
____ Sulfur Allergy	____ Taking Medications	____ Thyroid Problems
____ Tobacco Habit	____ Tuberculosis	____ Tumors
____ Ulcers	____ Venereal Disease	

Do you have any other health issues or allergies?

What is the reasons for your dental visit today? _____

When was your last visit to the dentist (if to a different office)? _____

Prior Dentist's name and address? _____

Please mark any of the following to indicate Yes in response to the question:

____ Do your gums bleed when you brush or floss?

____ Do your teeth experience sensitivity to cold or hot temperatures?

____ Are any of your teeth currently causing you pain?

____ Do you grind your teeth (either consciously or during sleep)?

____ Are any of your teeth loose?

____ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examinations for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

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.

Privacy Officer: **Tracey Frye**

Telephone: **(330)334-7645**
Fax: **(330)335-2322**

Address: **675 High Street Suite A**
Wadsworth, OH 44281

Premier Family Dental
DR. SHAHIR KHALIL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices (see in-office clipboard)

_____ _____

-Signature- -Date-

I authorize Premier Family Dental, regarding anything pertaining to dental treatment, to:
Speak to the following people:

Spouse _____

Other (s) _____

-For Office Use Only -

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please specify)

_____