Health History Form

Drs. Harrison, Tucker & Teel Family Dentistry
Milan, TN

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 ( ) | Cell Phone: Include area code ( )

Address: | City: | State: Zip:

Email Address | Date of Birth: | Sex: M F

SS#: | Emergency Contact: | Relationship: | Phone: Include area code ( )

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

Who may we thank for referring you to our office?

Medical Information

Allergies. Are you allergic to or have you had a reaction to any of the following:
To all yes responses specify type of reaction

	Yes	No	
Local anesthetics	☐	☐	
Aspirin	☐	☐	
Penicillin or other antibiotics	☐	☐	
Codeine or other narcotics	☐	☐	
Metals	☐	☐	
Latex (rubber)	☐	☐	
Other:	☐	☐	

Do you take Blood Thinner (aspirin)? Yes ☐ No ☐

Joint Replacement. Have you had an orthopedic total joint (hip,knee,elbow,finger) replacement? Yes ☐ No ☐
Date:_____ If yes, have you had any complications? ☐ ☐

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart(Congenital Heart Disease)	☐	☐
Unrepaired, Cyanontic CHD	☐	☐
Repaired (Completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Cancer/Chemotherapry	☐	☐
Radiation Treatment	☐	☐

Type & Diagnosis Date _____
_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes ☐ No ☐

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ☐ No ☐

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

_____
_____
_____
_____

	Yes	No		Yes	No
Autoimmune disease	☐	☐	Cardiovascular disease	☐	☐
Heart attack	☐	☐	AIDS or HIV infection	☐	☐
Diabetes Type I or II	☐	☐	Abnormal bleeding	☐	☐
Melanoma	☐	☐	Pacemaker	☐	☐
Asthma	☐	☐			

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? Yes ☐ No ☐
Date Treatment began:

WOMEN ONLY Are you:	Yes	No
Pregnant?	☐	☐
Number of weeks: _____		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐
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 doctor and his/her staff will rely on this information for treating me. I ackowledge that my questions, if nay, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, 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:

HIPPA INFORMATION:

The Health Insurance Portability and Accountability Act (HIPAA)provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U. S. Department of Health and Human Services. **www.hhs.gov**

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. this specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/ or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include phi by government Agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However , we are not obligated to alter internal policies to conform to your request.

VERIFYING INSURANCE/INSURANCE PAYMENT:

NEW INSURANCE as well as CHANGES IN INSURANCE must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility. As a courtesy to you, we will verify your insurance for eligibility benefits prior your appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us.

I_____ hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity, All remaining balances on your treatment plans that are not covered by your insurance , are your financial responsibility.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

PAYMENT:

Payment is due AT THE TIME OF SERVICE. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well. Once treatment is rendered, no refunds will be issued. If additional procedures are required during the course of treatment, the patient is responsible for the cost of additional treatment.

CHANGES IN PERSONAL INFORMATION:

Changes in your address or telephone numbers should be kept current with our office. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.

I,_____ HEREBY CONSENT AND ACKNOWLEDGE MY AGREEMENT TO THE TERMS SET FORTH ABOVE AND ANY SUBSEQUENT CHANGES IN OFFICE POLICIES.

_____ _____

Signature Date

_____ _____

Parent/Guardian Signature (If Necessary Date

Patient or Parent/Guardian

The following is for: ☐ the patient's spouse ☐ the person responsible for pay

Name: _____

☐ Male ☐ Female _____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____ **Best time to call:** _____

Address: _____

Street Apartment#

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ **Occupation:** _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ **Is insured a patient?** ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group#:** _____

Insured's Address: _____ _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ **Is insured a patient?** Yes No

Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group#:** _____

Insured's Address: _____ _____

Street City State Zip Code

Insured's Employer Name: _____ _____

Address: _____ _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office,financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1.5% (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

If your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all reasonable collection fees including collection fees, reasonable attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by the Doctor,or at my request, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of guarantor for payment/responsible party