SMILES BY HAZEN

2019 ANNUAL HEALTH HISTORY UPDATE

Patients Name: _____ DOB: _____

Cell: _____ Home: _____ Work: _____

Address: _____

SS#:_____ Emergency Contact: _____

Email: _____ Employer:_____

◯ Heart Problems	◯ Pregnant?	◯ Blood Thinners?	◯ Stroke
◯ High Blood Pressure	◯ Allergy to Anesthetics	◯Measles	◯Typhoid Fever
◯ Low Blood Pressure	◯ Allergies to Medication?	◯ Mumps	◯ Tonsillitis
◯ Circulatory Problems	◯ Anemia	◯ Psychiatric Care	◯ Tuberculosis
◯ Nervous Problems	◯ Arthritis	◯ Rheumatic Fever	◯ Ulcer
◯ Radiation Treatments	◯ Asthma	◯ Scarlet Fever	◯ Artificial Joints
◯ Excessive Bleeding	◯ Diabetes	◯ Sinus Problems	◯ Verified By:

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment?

ARE YOU ALLERGIC TO ANY MEDICATIONS?

◯ PENICILLIN ◯CODEINE ◯ASPIRIN ◯NOVOCAINE ◯OTHER: _____

HAVE YOU EVER TESTED POSITIVE FOR:

◯HEPATITIS ◯AIDS/HIV ◯VENEREAL DISEASE

LIST OF CURRENT MEDICATIONS: _____

PHARMACY PREFERENCE: _____ PHARMACY PHONE #: _____

PHYSICIANS NAME: _____ PHYSICIANS PHONE #: _____

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

I authorize payment of any dental benefits to the named provider for professional services rendered. INITIAL: _____

RELEASE INFORMATION

I authorize the release of any dental information necessary to proceed with dental claim if insurance is being used. INITIAL: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____