Health History Form

Patient's Name _____ Date of Birth ____/_____/_____

Gender: Male / Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

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MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. _____ _____	Yes	No
Prescription pain medication?	Yes	No			

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____

Printed name of patient, parent, guardian/Relationship

HEALTH HISTORY UPDATE

Date	Comments	
_____	_____	_____
_____	_____	_____

Patient Information

Name_____ Sex: ( ) Male ( ) Female

D.O.B. _____ SSN_____DL#_____

Home Address_____

City_____ State_____ Zip_____

Billing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Would you like to be confirmed via text or email? (Y) (N)
Best number to send text's to: _____
Email: _____

Person to Contact in Case of Emergency

Name_____ Relation to Patient_____ Phone_____

Medical Insurance

Insurance Company Name_____
Claims Address_____
Phone _____Group Number_____ID Number_____
Insured's Name_____Relation to Patient _____
Insured's DOB_____SSN_____Employer_____

Dental Insurance

Insurance Company Name_____
Claims Address_____
Phone _____Group Number_____ID Number_____
Insured's Name_____Relation to Patient _____
Insured's DOB_____SSN_____Employer_____

I understand that even though I have some insurance coverage, I am responsible for payment of services. I authorize release of information to my insurance company and referring dentist/physician. I hereby authorize my insurance company to release payment directly to James B. Phillips, MS, DDS, FICD, FAACS, PA. I have completed this form fully and certify that I am the patient and /or dully authorized agent of the patient authorized to furnish the information request. I hereby acknowledge that I have received a copy of these practices, notice of privacy practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature_____ Date_____

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

__ Home Telephone_____
__ Ok to leave message with detailed information
__ Leave message with call-back number only

__ Work telephone_____

__ Written Communication
__ Ok to mail my home address
__ OK to mail my work/office address
__ Ok to fax to number indicated
__ Ok to text to cell phone

__ Other (Fax/Cell, etc.)_____
_____

I allow you to give my clinical information to or answer questions from (check all that applies):

__ Spouse
__ Parent
__ Child
__ Other (specify):_____
__ None

_____ _____

Patients Signature (Parents Signature if pt is under 18) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

JAMES B. PHILLIPS, MS, DDS, PA

If you wish to obtain a copy of our privacy practices, please inform the staff upon returning this form.

I have received a copy of James B. Phillips, MS, DDS, PA, Notice of Privacy Practices which describes how my health information is used and shared. I understand that James B. Phillips, MS, DDS, PA, has the right to change this notice at any time. I may obtain a current copy by contacting the Facility Privacy Officer, or by visiting the Facility website at www.drjamesbphillips.com.

My signature below acknowledges a copy was offered/received. **(Not necessarily read).**

_____ _____

Signature of Patient Date

_____

Printed Name

_____

Personal Representative and Title (e.g. Guardian, Executor of Estate, Power of Attorney)

_____

FOR FACILTITY USE ONLY:

If the patient or patient's representative is unwilling or unable to sign this Acknowledgement, state the reason and describe the steps taken to obtain the signature.

_____

_____

_____ _____

Facility Representative Signature Date

_____

Printed Name

Dr. James B. Phillips, MS, DDS, FICD, FAACS, PA

PATIENT NO-SHOW, LATE SHOW, AND CANCELLATION POLICY

Dear Patient:

When we make your appointment, we are reserving a time slot for you with the doctor. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible for us to give your reserved slot to another patient.

We make every effort to be on time for all our appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, rushing or "squeezing in" an appointment shortchanges the patient and contributes to decreased quality of care (and increases medical errors). In light of this, **patients arriving more than 5 minutes after their appointment time will be asked to reschedule.** We apologize for any inconvenience this might cause.

Repeated cancellations or missed appointments will result in loss of all future appointment privileges.

By implementing this policy, we believe we honor patients who schedule/keep appointments, while also trying to accommodate everyone inn a fair and efficient manner. Thank you for your cooperation.

_____

Printed Name Date

_____

Signature