MAHTOMEDI FAMILY DENTAL

Date: _____

Patient Information (Confidential)

Name_____MI_____ Birthdate_____ Phone_____

Address_____ City_____ State_____ ZIP_____

Cell Phone_____ Work Phone_____ Preferred Contact Number_____

_____Minor _____Single ____Married ____Divorced ____Widowed _____Separated

Employer _____Phone _____

If Student, Name of College_____ City_____ State_____

Name of Parent/Guardian_____ Work Phone_____

Person to Contact in Case of Emergency_____ Phone_____

Email for appointment reminders_____

Would you prefer to have appointment reminders by SMS text message? Y/N

Who may We Thank for referring you? _____

Name of previous Dentist_____Phone_____

Date of Last Exam_____

Responsible Party

Name of Person responsible for this Account_____ Home Phone_____

Relationship to Patient_____ Cell Phone_____ Birthdate_____

Address_____

Email_____

Dental Insurance Information

Subscriber/policy holder_____ Birthdate_____/_____/_____

Relationship to Patient_____ Medical Assistance Program ☐ Yes ☐ No

Employer/Plan Name _____ Group#_____

ID#/SS_____Insurance Company_____

Insurance Co. Address_____ Ins Phone# _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? ☐ YES ☐ NO

Name of Insured_____ Birthdate_____

Relationship to Patient_____ Medical Assistance Program ☐ Yes ☐ No

Employer/Plan Name _____ Group#_____

ID#/SS_____Insurance Company_____

Insurance Co. Address_____ Ins Phone# _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur Heart ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Pacemaker Heart ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Authorization to Disclose Health Information to Family Members and Friends

Patient Name _____ Date of Birth ___/___/____

I hereby authorize Mahtomedi Family Dental to release my patient health information as described below:

NAME	RELATIONSHIP	Information Allowed to Disclose (check one or both)	
		DENTAL	**BILLING**

Protected Health Information("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the health Insurance Portability and Accountability Act of 1996, and its implementing regulations("HIPPA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in Mahtomedi Family Dental's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that Mahtomedi Family Dental may not condition treatment on my execution of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

[Check One**] I DO___ DO NOT___ GIVE PERMISSION** to Mahtomedi Family Dental, to leave information on my voicemail, email, text and / or with my family members in regard to treatment plans, referrals, test results and / or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time ,date ,location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare of Mahtomedi Family Dental. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, Mahtomedi Family Dental will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient or Personal Representative [i.e. Guardian] Relationship of Personal Representative to Patient

Date of Authorization _____