

MEDICAL HISTORY

Patient Name _____

Date _____

Dental History

Are you happy with the appearance of your teeth? (color, shape, size)	Yes	No
Are your teeth temperature sensitive? (hot or cold)	Yes	No
Are your teeth sensitive while biting or chewing?	Yes	No
Do you frequently get cold sores, blisters, or other types of oral lesions?	Yes	No
Have you ever had orthodontic treatment? (Braces)	Yes	No
Do you brush and floss your teeth on a regular basis?	Yes	No
Does food become stuck between certain teeth?	Yes	No
Do your gums bleed?	Yes	No
Are you using any dental aids? Yes _____		No
Would you like to keep your remaining teeth?	Yes	No
Do you ever have clicking, popping, or discomfort in the jaw joint?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you use any form of tobacco? (cigarettes, pipe, chewing tobacco)	Yes	No
What was the date of your last dental exam? _____		
What was the date of your last full mouth x-ray? _____		

Medical History

Women: Are you...

pregnant/trying to become pregnant?	Yes	No
taking oral contraceptives?	Yes	No
nursing?	Yes	No

Allergies

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetic
 NSAIDS Sulfa Other (please list) _____

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

<input type="checkbox"/> AIDS/ HIV positive	<input type="checkbox"/> Diet, special or restricted	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Fainting/dizzy spells	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Blood Transfusions	Describe _____	<input type="checkbox"/> Sleep Apnea/ Snoring
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hepatitis A,B, or C (please circle)	<input type="checkbox"/> Swelling of Feet/Ankles
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Liver Disorder/ Jaundice	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cough (Persistent)	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease
		<input type="checkbox"/> Xerostamia (Dry mouth)

If you have any other serious illnesses/conditions not listed above please list and explain them here.

Are you under a physician's care now? Yes No If yes please list Dr's name and # _____

Are you taking any prescription medications, herbal supplements, or over-the-counter drugs Yes No

If yes, please list all medications taken: _____

Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment from your insurance company (if applicable) for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Unless you request otherwise, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Patients 18 years and over will be considered as an adult and will be responsible for making their own decisions in regards to their dental care.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your

health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies of recent radiographs, we will fulfill your request free of charge. However, if you require any further chart history or a summary of your dental information, we will charge you \$25.00 for staff time to process this request. Contact us using the information listed at the end of this Notice for a full explanation of this policy.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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.

Contact Officer: Susan Hedlund _____

Telephone: (248) 656-2020 _____ Fax: (248) 656-2559 _____

E-mail: _____

Address: 433 W. University Rochester, Mi, 48307 _____

**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.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

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

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