MEDICAL HISTORY

Clear Creek Family & Cosmetic Dentistry

NAME: _____ TELEPHONE: _____ DATE: _____

ADDRESS: _____

SSN: _____ DOB: _____ EMERGENCY CONTACT: _____

Although dental personnel primarily treat the area in and around your mouth, is 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, Phe-Fen or Redux? ◯ Yes ◯ No _____

Are You on a special diet? ◯ Yes ◯ No _____

Do you use tabacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Woman: 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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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:

Clear Creek Cosmetic and Family Dentistry Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 254-200-1983.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Clear Creek Cosmetic and Family Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Clear Creek Cosmetic and Family Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Clear Creek Cosmetic and Family Dentistry.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Clear Creek Cosmetic and Family Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I _____ have reviewed Clear Creek Cosmetic and Family Dentistry Privacy Policy.

Signed_____ Date

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our office manager.
- For patients with Dental Insurance:
- **We will file your claim for you at *no charge*, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.**

  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, American Express and Care Credit as well as checks and cash.
- Payment for the use of nitrous oxide and oral sedation will be due at the time of treatment, and will be collected before your treatment will begin.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a 48-hour notice.** Repeated cancellations or failures could result in a broken appointment charge or no reappointment.
- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge will be assessed monthly on all overdue balances.***

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____ (Patient, Parent or Guardian)