Confidential Health History Information

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Personal Health Information

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Please answer the following questions to the best of your ability:

Have you been hospitalized within the past 2 years?
Yes □ No □
If yes, for what? _____
_____

Are you currently being treated by a physician? Yes □ No □
If yes, for what? _____

Are you currently taking and medicines or drugs? Yes □ No □
What? _____

Have you ever received counseling for excessive use of alcohol and/or prescription drugs? Yes □ No □

Are you allergic to any drugs? Yes □ No □
If yes, what? _____

Have you ever had a skin rash or other reaction to metal jewelry? Yes □ No
What? _____

Do you bleed excessively upon injury? Yes □ No □

Are you pregnant? Yes □ No □

Have you ever been involved with dental/medical legal activity? Yes □ No □

Please Check Any of the Following Conditions That You Have Had in the Past or Now Have:

- □ AIDS
- □ Arthritis
- □ Asthma
- □ Cancer
- □ Diabetes
- □ Epilepsy
- □ Glaucoma
- □ Heart Murmur
- □ Heart Problem
- □ Hepatitis
- □ High Blood Pressure
- □ Jaundice
- □ Hepatitis ABC (circle one)
- □ Herpes
- □ Artificial Joints
- □ Chemotherapy/Radiation
- □ Kidney Problems
- □ Low Blood Pressure
- □ Nervous Breakdown Or Psychiatric Therapy
- □ Osteoporosis
- □ Rheumatic Fever
- □ Sexually Transmitted Diseases
- □ Stroke
- □ Tuberculosis
- □ Anemia
- □ Latex Allergy
- □ Surgical Implants
- □ Other _____ _____

Person to Be Contacted in Case of Emergency

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

Confidential Patient Information

Date: _____

PERSONAL INFORMATION
Name: _____ SS #:_____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____
(Cell) _____ E-mail: _____
Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____
Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)
Name: _____ SS #: _____
Relationship to Patient: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION
Primary Insurance Co: _____ Policy #: _____
Group #: _____ Subscriber Name: _____
SS #: _____ Relationship: _____ Birth date: _____
Secondary Insurance Co: _____ Policy #: _____
Group #: _____ Subscriber Name: _____
SS #: _____ Relationship: _____ Birth date: _____

I understand that payment is my obligation regardless of insurance or any other third-party agreement.

_____ _____

Patient/Guardian Signature Date

Hillsboro Dental Excellence

324 SE 9th Ave Ste. B, Hillsboro, OR 97124 – (503) 648-6671

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

***** 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}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
{Please Print Name} {Relationship}

_____ _____
{Please Print Name} {Relationship}

_____ _____
{Please Print Name} {Relationship}

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 _____
☐ Communication barriers prohibited obtaining the acknowledgement. _____
☐ An emergency situation prevented us from obtaining acknowledgement _____
☐ Other (please specify)

Smile Evaluation (Optional)

Do you like your smile? Yes □ No □
If no, and you could change anything about your smile, what would you change?

_____

Are you happy with the color of your teeth? Yes □ No □

Would you like your teeth to be whiter? Yes □ No □

Would you like your teeth to be straighter? Yes □ No □

Do you have spaces between your teeth that you would like closed? Yes □ No □

Would you like your teeth to be longer? Yes □ No □

Do you like the shape of your teeth? Yes □ No □

Explain: _____

Do you have missing teeth that you would like replaced? Yes □ No □

Explain: _____

Do you have old silver fillings that you would like replaced with tooth-colored fillings? Yes □ No □

Would there be any reason not to go ahead with any needed dental treatment? Yes □ No □

Explain: _____

What makes you most comfortable in a dental practice? What can we do to achieve this?

Explain: _____

What makes you least comfortable in a dental practice?

Explain: _____