

HEALTH HISTORY

Name _____ Date _____ Date of Birth _____

Mailing Address _____ City _____ State _____ ZIP _____ Phone _____

Are you allergic or have you had a reaction to:

- | | | |
|---|----|-----|
| a. Local anesthetics | No | Yes |
| b. Penicillin or other antibiotics | No | Yes |
| c. Aspirin, Ibuprofen or Tylenol | No | Yes |
| d. Codeine, Valium* or other sedatives..... | No | Yes |
| e. Latex or Metals..... | No | Yes |
| f. Other (please specify)_____ | | |

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma?	No	Yes	Kidney Disease?	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease? (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes?	No	Yes
Diabetes?	No	Yes	Psychosis?	No	Yes
Emphysema or other Respiratory/Lung Illnesses?	No	Yes	Previous Biopsies?	No	Yes
Epilepsy?	No	Yes	Radiation or Chemotherapy Treatment?	No	Yes
Fainting or Dizzy Spells?	No	Yes	Rheumatic Fever?	No	Yes
Glaucoma?	No	Yes	Slow-Healing Mouth Sores?	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis?	No	Yes	Unintentional Weight Loss/Gain?	No	Yes
Heart Valve (artificial) or Heart Transplant?	No	Yes	H.I.V. Infection/AIDS or ARC?	No	Yes
Congenital Heart Disease?	No	Yes	Venereal Disease?	No	Yes
Heart Disease, Heart Attack, Heart Surgery?	No	Yes	Other Conditions?	No	Yes
Heart Stent? When Placed?	No	Yes	Sleep Apnea?	No	Yes
Stop Breathing During Sleep?	No	Yes	CPAP Therapy?	No	Yes
Restless Sleep?	No	Yes	Gasping During Sleep?	No	Yes
Snoring?	No	Yes			

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? _____			When did the treatment end? _____		
Have you ever taken any prescription drugs such as fen-phen for weight loss?			No	Yes	
Do you consume grapefruit juice, grapefruits or grapefruit extract?			No	Yes	

Please list any medications you are currently taking and dosages:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"?
 What is your normal blood pressure? S /D Today: _____ / _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): *none slight moderate high*

How did you hear about Dentistry With TLC? _____

What is the persons name who referred you to Dentistry With TLC? _____

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

DOCTOR'S USE ONLY

Existing prostheses and date of service:

Comments on patient interview concerning medical history and dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of changes in my health and medication at the beginning of all my future appointments at Dentistry With TLC.

Patient (Print Name)

Patient Signature

Date

Doctor Signature

Date

How did you hear about us? _____ (Ad or Referral Source)

Thank you for coming to Dentistry With TLC. We are always welcoming new patients, and we're always curious how you heard about us. Please use the check list below and mark any source where you may have seen or heard our name.

Thank you for your assistance.

<p>Newspaper</p> <ul style="list-style-type: none"> <input type="checkbox"/> Advantage <input type="checkbox"/> Bunker Hill Gazette <input type="checkbox"/> Flair Magazine <input type="checkbox"/> Southwestern Journal (Brighton Paper) <input type="checkbox"/> Alton Telegraph <input type="checkbox"/> Other _____ 	<p>Phone Book</p> <ul style="list-style-type: none"> <input type="checkbox"/> AT&T Bigbook <input type="checkbox"/> Hometown Phonebook, Alton-Godfrey <input type="checkbox"/> Hometown Phonebook, Tri-County <input type="checkbox"/> Jersey County Yellow Book <input type="checkbox"/> Other _____
<p>Television</p> <ul style="list-style-type: none"> <input type="checkbox"/> Great Day St. Louis – Channel 4 <input type="checkbox"/> Charter Network <input type="checkbox"/> HGTV <input type="checkbox"/> Discovery <input type="checkbox"/> E! <input type="checkbox"/> Fox News <input type="checkbox"/> ESPN <input type="checkbox"/> CNN <input type="checkbox"/> TBS <input type="checkbox"/> History Channel <input type="checkbox"/> Food Network <input type="checkbox"/> Other _____ 	<p>Internet</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1-877-Lumineers <input type="checkbox"/> Insurance Company <input type="checkbox"/> DentistryWithTLC.net <input type="checkbox"/> FaceBook <input type="checkbox"/> Yellowbook.com <input type="checkbox"/> 1-800-Dentist <input type="checkbox"/> RiverBender.com <input type="checkbox"/> Other _____
<p>Radio</p> <ul style="list-style-type: none"> <input type="checkbox"/> WBGZ 1570 AM <input type="checkbox"/> KFTK 97.1 FM <input type="checkbox"/> WIBI 91.1 FM <input type="checkbox"/> KSD “93.7 The Bull” FM <input type="checkbox"/> KTRS AM <input type="checkbox"/> Other _____ 	<p>Local Events</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bridal Show <input type="checkbox"/> Dentistry with a Heart Day <input type="checkbox"/> Health Fair <input type="checkbox"/> Other _____
<p>Personal Referral</p> <ul style="list-style-type: none"> <input type="checkbox"/> Family/Friend <input type="checkbox"/> Family Doctor/Local Hospital <input type="checkbox"/> Local Business <input type="checkbox"/> Dentistry w/TLC Business Cards <input type="checkbox"/> Other _____ 	<p>Mail Box</p> <ul style="list-style-type: none"> <input type="checkbox"/> Money Mailer <input type="checkbox"/> New To The Area Letter <input type="checkbox"/> News and Views Newsletter <input type="checkbox"/> Welcome Wagon <input type="checkbox"/> Other _____
<p>Insurance Company</p> <ul style="list-style-type: none"> <input type="checkbox"/> Personal Insurance <input type="checkbox"/> Employer Insurance <input type="checkbox"/> Other _____ 	<p>Signs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dentistry w/TLC Building Sign <input type="checkbox"/> Other _____

Name _____

Account _____

HIPAA Notice of Privacy Practices

Effective as of April/14/2003

Dentistry With TLC
1317 D'Adrian Professional Park
Godfrey, IL 62035
618-466-0733

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Dentistry With TLC's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)

Date

Signature

Patent Evaluation Form

1. How did you hear about our practice?

- Referred by a friend
- Directory of dentist provided by my Insurance Company
- I saw one of your advertisements
- Walk by or drove by the practice

2. Date of your last cleaning visit: _____

3. On a scale of 1 to 5 (1 being bad, 5 being good) please rate how you feel your overall dental health is.

1 2 3 4 5

4. On a scale of 1 to 5 (1 being bad, 5 being good faithful) Over the last ten years rate how faithfully you have had your teeth cleaned?

1 2 3 4 5

5. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your level of sensitivity to dental procedures?

1 2 3 4 5

6. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your sensitivity to cleaning visits?

1 2 3 4 5

7. Rate how you feel about your smile and the look of your teeth. (1 being unhappy, 5 being very happy)

1 2 3 4 5

8. Are you interested in regular cleanings?

- Yes
- No

9. What is the main reason for your visit today?

- Tooth Pain
- I need a check up
- Cleaning
- Orthodontics (braces)
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Other _____

10. I would like to learn more about?

- Orthodontics
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Implants
- Bridges
- Veneers
- Dentures
- Other _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____
LAST FIRST MI Mr. Mrs. Ms. Dr.
CIRCLE ONE

Address: _____
NUMBER & STREET CITY STATE ZIP

(_____) _____ (_____) _____ (_____) _____
HOME PHONE WORK PHONE CELL PHONE

M F _____ / _____ / _____
SEX MARITAL: M D S W DOB SOCIAL SECURITY NUMBER EMAIL ADDRESS

OCCUPATION EMPLOYER FULL TIME PART TIME
CIRCLE ONE

INSURANCE INFORMATION

Employer: _____
COMPANY NAME ADDRESS - NUMBER & STREET

Address: _____
CITY STATE ZIP (_____) EMPLOYER PHONE

GROUP NUMBER ID NUMBER

INSURANCE COMPANY NAME INSURANCE COMPANY ADDRESS - NUMBER & STREET

CITY STATE ZIP (_____) INSURANCE PHONE

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY OCCUPATION EMPLOYER FULL TIME PART TIME
CIRCLE ONE

Name: _____
LAST FIRST MI Mr. Mrs. Ms. Dr.
CIRCLE ONE

Address: _____
NUMBER & STREET CITY STATE ZIP

(_____) _____ (_____) _____ _____
HOME PHONE WORK PHONE EXT SOCIAL SECURITY NUMBER M F
SEX BIRTHDAY

ADDITIONAL INFORMATION

Spouse: _____
FIRST NAME MI DOB SOCIAL SECURITY NUMBER (_____) WORK PHONE

SPOUSE'S OCCUPATION EMPLOYER

AUTHORIZATION AND RELEASE: I authorize Dentistry with TLC to release any information, including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such dental care, to third party payers and/or healthcare practitioners. I authorize Dentistry with TLC to evaluate my credit record through any credit reporting agencies. I authorize and request my insurance company to pay directly to the dentist or dental group dental benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All accounts that are past 30 days will be subject to a 1.5% monthly finance charge (18% yearly), plus all cost of collections, if necessary.

Signature: _____ Date: _____