Health History Form

Date _____

Name_____ Home Phone (____)_____ Cell (____)_____ Work (____)_____

Address_____ City _____ State _____ Zip Code_____

Occupation_____ Height _____ Weight _____ Date of Birth _____ Sex ☐ M ☐ F

SS#_____ Emergency Contact_____ Relationship_____ Phone (____)_____

E-mail Address_____Who referred you to our practice? _____
Name relationship

DENTAL INFORMATION

Please select the level of care you desire from our office:

☐ Emergency care as needed
☐ Consultation to solve a specific problem or issue
☐ Routine examination and preventative care
☐ Comprehensive care, optimal dental health and appearance

List the 3 most important factors you desire from your dental office?

_____
_____
_____

How would you describe your current dental situation?_____

Date of your last dental appointment?_____

What was done at that time? _____

How do you feel about the appearance of your teeth?_____ Do you have any problems with bad breath?_____

YES	NO	UNSURE		YES	NO	UNSURE	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain_____				

_____

MEDICAL INFORMATION

YES	NO	UNSURE	
☐	☐	☐	Are you in good health?
☐	☐	☐	Have there been any changes in your health within the past year?_____
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated?_____
			_____Date of last exam_____
			Physician(s)_____
			Name Phone Address City/State/Zip
			_____
			Name Phone Address City/State/Zip
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem?_____
☐	☐	☐	Do you wear contact lenses?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week?_____month?_____ If yes, _____# drinks per day for _____# of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so have you received treatment? (check one) ☐ YES ☐ NO
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _____
☐	☐	☐	Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all How many years have or did you use tobacco? _____ How much tobacco did you use per day? _____

Are you taking any medications? If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DOSE

Are you allergic to or have you had a reaction to?	YES	NO	UNSURE
Penicillin or other antibitoics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐

Other (specify)_____

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	UNSURE
Abnormal Bleeding	☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion If yes, date_____	☐	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases? If yes, please specify	☐	☐	☐
_____Angina Pectoris			
_____ Heart murmur			
_____Bypass Sugery			
_____Mitral Valve Prolapse			
_____Pacemaker			
_____Rheumatic fever			
_____High Blood Pressure			
_____Artificial valves			
_____Heart attack Date_____			
Chest Pain upon exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, please specifiy	☐	☐	☐
_____Insulin dependent _____ Non-Insulin dependent			
Dry mouth	☐	☐	☐
Eating disorder. If yes, please specify_____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
G. Glaucoma	☐	☐	☐
Kidney Disease/	☐	☐	☐

	YES	NO	UNSURE
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
Reccurent Infection	☐	☐	☐
If yes, indicate type of infection_____			
Mental Health disorder	☐	☐	☐
Night Sweats	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistant swollen glands	☐	☐	☐
Respiratory problems.	☐	☐	☐
If yes, please specify:			
___Emphysema ___Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
If yes, date_____			
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Joint replacement	☐	☐	☐
Do you have any disease not listed above that you think we should know about?	☐	☐	☐
Please Explain:_____			
Have you ever been told you needed to premedicate before your dental appointment?	☐	☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take because of errors or ommission that I may have made in the completion of this form.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Name of Responsible Party: _____ Social Security #: _____

DOB: _____ Relationship to patient: _____ Phone: _____

Address: _____

Name of Insured: _____ DOB: _____

Employers Name: _____ Group #: _____

ID #: _____ Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

All estimated co-payments are due at the time the service is rendered unless otherwise is stated in advance. Different insurance companies may vary in co-payments and additional charges may be applied.

Please keep in mind cancelled appointments and no shows are subject to a $65 charge. Also returned checks will be assessed a $35 fee.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient: _____ Date: _____

Communication Preference

Please communicate via: Home Phone: Y / N Mobile Phone: Y / N

Phone # to use: (_____) _____ - _____

My Preferred Method of Communication is: Text message: Y / N Short phone call Y / N

* Text message requires mobile # (_____) _____ - _____

E-Mail Option: Please copy messages and appt. reminders via e-mail Y / N

E-Mail Address _____

I authorize Malcolm J Murray, DDS to contact me via direct mail, e-mail, mobile text message (standard txt & data rates may apply), or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me. I understand that I can opt-out of these communications at any time by informing the front desk.

Patient Name: _____ Patient Signature: _____

Insurance Policy

We do our best to provide you with the closest estimate for your treatment. We gather the percentages for procedures and the insurance fees (if in-network applies) for each procedure. It is ultimately up to you to know your insurance plan coverage. If a procedure is denied or your portion is higher than what is estimated you will be responsible for the charges.

Issues you should know that can reflect procedure coverage:

- Waiting period
- Downgrade to silver/gold restorations on back teeth
- Missing tooth clause
- Pocket depths not high enough for benefits
- Frequency of procedure
- Annual maximum met

Please feel free to discuss these situations with us if you have any questions regarding the issues above.

Patient Signature: _____ Date:_____

Malcolm J. Murray, D.D.S.
3941 Old Lee Highway
Fairfax, Va 22030
(703)934-5540

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entitles that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conduction quality assessment and improvement activities, audition functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assisted it taking care of you. We will use and disclose your treatment when we are required to do so by federal, state and local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if your are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protection the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organs, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose you PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious thereat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person to organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMTION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other or foreign heads of state, or to conduct investigations. We my disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials. If you are the inmate or under the custody of the law enforcement official disclosure for those purposes would be necessary: (a) for the Institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers compensation and similar programs.

Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restriction on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right request a amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosure of PROTECTED HEALTH INFORMATION outside the treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from the office.

You have the right to file a formal; written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel you privacy rights have been violated. We will not retaliate against you for filing a complaint.

MJM Family and Cosmetic Dentistry
3941 Old Lee Highway
Fairfax, Va 22030