Health History Form

E-mail: Today's Date:

American Dental Association
www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Sex: M F DOB: SSN: Status: Child Single Married Divorced Other

Address: City: State: Zip: Home Phone: Cell Phone:

Insurance Information: Employer: Subscriber Name: DOB: Subscriber ID: SSN: Group Number:

Insurance Company: Policy Holder Name: Relationship To Subscriber:

Whom may we thank for referring you to the practice?

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

☐

FOR OFFICE NOTES:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, Specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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 or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date: | Docter Signature:

LIST OF MEDICATIONS AND USE:

_____

_____

_____

_____

_____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Mary E. Gregory, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Mary E. Gregory, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Mary E. Gregory, DDS
4500 Old Dominion Drive * Arlington, Virginia * 22207 * 703-527-6495

Mary E Gregory DDS
Electronic Communication Agreement

Electronic communications, including but not limited to, emails and text messages, for example (hereinafter "Electronic Communications"), provide an opportunity to communicate with the office of Mary E Gregory DDS.

The following is intended to assist you with your determination of whether you wish to electronically communicate with Mary E Gregory DDS.

General Considerations

- As your healthcare provider, Mary E Gregory DDS, will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Mary E Gregory DDS has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended ("HIPAA").
- Standard email services, including, but not limited to, AOL, Yahoo, and Hotmail, are not secure. This means that the email messages, including any individually identifiable health information and other sensitive or confidential information that may be contained in such email messages, are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Mary E Gregory DDS. I acknowledge that commonly used Electronic Communications are not secure.

Please check one of the three below statements:

A. ____ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with Mary E Gregory DDS via Electronic Communications. I understand that I can withdraw this consent authorizing Mary E Gregory DDS to communicate with me via Electronic Communications at any time by written notification to Mary E Gregory DDS.

My email address is _____
My Cell Phone number is _____

B. ____ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with Mary E Gregory DDS via Electronic Communications *only with respect to appointment and treatment plan reminders*. I understand that I can withdraw this consent authorizing Mary E Gregory DDS to communicate with me via Electronic Communications at any time by written notification to Mary E Gregory DDS.

My email address is _____
My Cell Phone number is _____

C. ____ Having been informed of the risks associated with Electronic Communications, I do *not* consent to, accept the risk in and desire to communicate with Mary E Gregory DDS via Electronic Communications. I understand that I can change my mind and provide a consent authorizing Mary E Gregory DDS to communicate with me via Electronic Communications at a later time by written notification to Mary E Gregory DDS.

To the extent that I have checked Box A or B, I release and hold harmless Mary E Gregory DDS, its dentist(s) and their staff, employees, affiliates, agents, officers, and principals from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between Mary E Gregory DDS and me based on this authorization given to Mary E Gregory DDS to communicate with me via Electronic Communications.

_____
Patient Name (printed)

_____ _____
Patient Signature (Parent if Patient is a minor) Date

Consent for Services & Financial Policy

Thank you for choosing our office as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Consent for Service & Financial Policy, which we require you to read and sign prior to any treatment.

Please initial after each statement acknowledging that you have read and agree to the contents.

____I hereby authorize the doctor and/or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of me or my child's dental condition(s).

____Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

____I agree to the use of local anesthetics, sedatives, and other medications as necessary. I fully understand an anesthetic agent embodies certain risks.

Financial Policy:

____Payment in full is due at the time of service. We accept Cash, Personal Check, Visa, Master Card, Discover, American Express, Debit Cards, and Care Credit patient financing. Please be aware that a $35.00 fee will be charged for all returned checks.

____If you do not have dental insurance, we will collect the amount due for services at each appointment.

____I understand that it is ultimately my own responsibility to know who my insurance carrier is, and what coverage made available to me.

____If you have **DELTA DENTAL PRIMERE/PPO or CIGNA PPO** (in-network with Cigna PPO until January 31, 2018) insurance, we will do our best to confirm your coverage and you will be asked to pay only the ESTIMATED part of your bill at the time of service; that we think your insurance will not cover. However, do not file secondary insurance, that will be your responsibility to ask for any necessary forms and x-rays to send. Any unpaid balance can be charged on all accounts 60 days or more past due. Further collection activity and credit reporting will be initiated on all 90 days or more past due balances.

____We **CANNOT** guarantee what your insurance company will pay; we simply estimate the amount most insurance companies pay based on most traditional plans. We can submit a pre-treatment estimate before any major work is started (crowns, bridges, implants, dentures, etc.) to your insurance company. All major dental work is required to be paid in full before cementation or delivery.

____Your insurance policy is a contract between you and your insurance company. You are our patient and we will treat you, not your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will be sent to you in the form of a statement. You will then

have 21 days from the date of your statement to remit payment to us. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the dental provisions of your insurance plan. I understand that the co-payment or patient portion of payment is only an **ESTIMATE** and I will be responsible for any balance after the insurance payments are made.

____I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or practice and to be applied directly to any outstanding balance on my account.

____Adult patients are responsible for payment at the time of service. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time of service.

BROKEN APPOINTMENT POLICY: When you make your appointment, the doctors' and staffs' time is specifically reserved for you. When you cancel your appointment without giving us a 48 hour notice, the time we have reserved for your appointment cannot be replaced. Our office will charge and collect the full amount of your missed appointment fee of $85.

____I understand that any appointment over an hour in length will be charged an $85.00 cancellation fee if the appointment is canceled with less than 48 hours notice.

____I understand there will be a $200 deposit collected for any appointment over 1 1/2 hour. Refundable with 48-business hour notice (Saturday and Sunday are not business days).

____I understand that I will need to request in writing and pay a reasonable administrative fee if I want to have copies of my records.

Printed name of patient, parent or guardian/responsible party):_____

Signature: _____

Doctor/Staff Signature:_____Date: _____