



PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Dr. Hansen's Family Dentistry
Address: 1747 S. Heritage Lane Suite B203
City/State/Zip: Syracuse, Utah 84075
Phone: 801-525-1725



Dr. Hansen's Family Dentistry

1747 South Heritage Lane, Suite B203 • Syracuse, Utah 84075 • 525-1725

PATIENT MEDICAL HISTORY

- | | YES | NO |
|-------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 3. Are you taking any medication(s) including nonprescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | |
| 4. Have you ever taken Phen-Fen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|------------------------------------------------------------------------|--------------------------|--------------------------|
| 8. Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals (e.g. Nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---------------------------------------------------------|--------------------------|--------------------------|
| 9. Women Only | | |
| a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |

10. Do you have or have you had any of the following?.....

- | | YES | NO | | YES | NO | | YES | NO |
|----------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> | Angina..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting, Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy, Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or implant..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Other..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> | Explain..... | | |

PATIENT DENTAL HISTORY

- | | YES | NO |
|-------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps on or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head neck or jaw injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Difficulty in opening or closing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Difficulty chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of placement _____ | | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of any services rendered on my behalf or my dependents.

Signature _____

Date _____

Doctor's Comments _____

