CONFIDENTIAL PERSONAL & MEDICAL HISTORY

Name Mr., Mrs., Miss, Ms., Dr.: _____ Soc. Sec.# _____ Sex _____

Mailing Address _____ City _____ Zip _____

Birth Date _____ Home Phone _____ Cell Phone _____

Occupation _____ Employer _____ Business Phone _____

Regular Dentist _____ Who referred you to this office? _____

Physician _____ Your general health (circle one): Good Fair Poor

In case of emergency, whom should we contact? _____ Phone _____

Spouse's Name and birthdate _____ Employer _____ City _____

Primary Dental Insurance _____ Policyholder/ID# _____

Secondary Dental Insurance _____ Policyholder/ID# _____

Are you here because of an accident? YES ☐ NO ☐

Is this a Workman's Compensation claim? YES ☐ NO ☐

Pharmacy Preference _____

NOTE: We will assist you in providing documentation of fees for services provided.
You are responsible for all charges and for obtaining reimbursement from the insurance company.

Have you traveled outside of the U.S. in the last 6 months? YES ☐ NO ☐

Please check any of the following conditions that you have had or have at present:

- ☐ AIDS/HIV
- ☐ Alzheimers Disease
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Cancer/Type
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone Therapy, long term
- ☐ Diabetes
- ☐ Drug/Alcohol Addiction
- ☐ Epilepsy or seizure disorder
- ☐ Hemophilia
- ☐ Hepatitis A B C
- ☐ Jaw Problems
- ☐ Kidney Disease

Heart
- ☐ Artificial Valve
- ☐ Heart Attack/Stroke
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ High Blood Pressure

- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Psychiatric Care
- ☐ Sinus Conditions
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis

List any diseases, conditions or problems not noted above _____

Are you taking oral or IV medication for osteoporosis? ☐YES ☐NO Drug Name _____

List any other medicine or drugs you are presently taking _____

Are you allergic to any medicine, drug or other substance? ☐YES ☐NO If yes, what? _____

Have you ever had a complication during or after dental treatment? ☐YES ☐NO If yes, what? _____

Have you ever had an injury to your face or jaw? ☐YES ☐NO If yes, what? _____

Is there anything else about your physical condition you think we should know? _____

WOMEN: Are you pregnant? ☐YES ☐NO Due date _____ Nursing? ☐YES ☐NO Using birth control? ☐YES ☐NO

To the best of my knowledge, all of the preceding answers are true and correct. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY DR. MEIER. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement I have with my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late changes and all costs of collection including, but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorizes payment sent directly to Dr. Meier.

Date _____ Signature of Patient, Parent, Guardian or Responsible Party _____

FOR OFFICE USE: HIPPA Consent obtained _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/ USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to recf&ive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____

Or

____ I **decline** to receive communications via **text.**

____ I **decline** to receive communications via **email.**

Revocation - Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.

Click SUBMIT button to send your completed form to our office (only works in Adobe Acrobat).
If you're having problems, please give us a call at 812-333-6363.

SUBMIT