CUMMINGS FAMILY DENTIST

Ann Ullah, DDS

PATIENT MEDICAL HISTORY

Date _____

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

Patient Name: _____ Sex M F
Last First Middle

Parent's Name (if minor): _____

Address: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____ Spouse's Name: _____

Email Address: _____

Employer _____

1. Date of last physical examination _____
2. Are you under any medical treatment now? If so, what? ❒ Yes ❒ No
3. Have you been hospitalized within the last 5 years? ❒ Yes ❒ No
4. Have you had any major operations? If so, what? ❒ Yes ❒ No
5. Have you had abnormal bleeding after cuts, surgery, or dental extractions? ❒ Yes ❒ No
6. Do you bruise easily? ❒ Yes ❒ No
7. Have you ever had a blood transfusion? ❒ Yes ❒ No
8. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ❒ Yes ❒ No
9. Have you had chemotherapy? Dialysis? ❒ Yes ❒ No
10. Are you employed anywhere that exposes you to x-rays or ionizing radiation? ❒ Yes ❒ No
11. Do you use tobacco? ❒ Yes ❒ No

    Pipe _____ Cigars _____ Snuff _____ Chewing Tobacco _____ Cigarettes _____ Packs per day _____
12. Are you happy with the appearance of your teeth? ❒ Yes ❒ No
13. Do you have or have you ever had:

❒ Yes ❒ No	Heart ailment	❒ Yes ❒ No	Emphysema	❒ Yes ❒ No	Anemia
❒ Yes ❒ No	Rheumatic fever	❒ Yes ❒ No	Persistent cough	❒ Yes ❒ No	Diabetes
❒ Yes ❒ No	Rheumatic heart disease	❒ Yes ❒ No	Recurrent sore throat	❒ Yes ❒ No	Blood disease or disorder
❒ Yes ❒ No	Heart murmur	❒ Yes ❒ No	Sinus trouble	❒ Yes ❒ No	Hemophilia
❒ Yes ❒ No	Heart attack	❒ Yes ❒ No	Hay fever	❒ Yes ❒ No	Arthritis
❒ Yes ❒ No	Stroke	❒ Yes ❒ No	Allergies	❒ Yes ❒ No	Venereal disease or syphilis
❒ Yes ❒ No	Artificial heart valve	❒ Yes ❒ No	Skin rashes	❒ Yes ❒ No	Herpes
❒ Yes ❒ No	Pacemaker	❒ Yes ❒ No	Epilepsy or seizures	❒ Yes ❒ No	Stomach or intestinal problem
❒ Yes ❒ No	Chest pain	❒ Yes ❒ No	Fainting spells	❒ Yes ❒ No	Stomach ulcer
❒ Yes ❒ No	Shortness of breath	❒ Yes ❒ No	Liver disease	❒ Yes ❒ No	Tumor or growth
❒ Yes ❒ No	High blood pressure	❒ Yes ❒ No	Hepatitis or yellow jaundice	❒ Yes ❒ No	Thyroid problem or hormone deficiency
❒ Yes ❒ No	Respiratory or lung disease	❒ Yes ❒ No	Kidney disease		
❒ Yes ❒ No	Tuberculosis	❒ Yes ❒ No	Steroid therapy	❒ Yes ❒ No	Glaucoma or other eye problem
❒ Yes ❒ No	Scarlet fever	❒ Yes ❒ No	AIDS, AIDS related condition or HIV positive	❒ Yes ❒ No	Contact lenses
❒ Yes ❒ No	Asthma			❒ Yes ❒ No	Implant/prosthesis
				❒ Yes ❒ No	Prosthetic joint replacement

14. Are you allergic or have you ever reacted adversely to:
    - ❒ Yes ❒ No a. Local anesthetic (such as novacaine)
    - ❒ Yes ❒ No b. Penicillin
    - ❒ Yes ❒ No c. Sulfa drugs
    - ❒ Yes ❒ No d. Barbiturates, sedatives or sleeping pills
    - ❒ Yes ❒ No e. Aspirin
    - ❒ Yes ❒ No f. Codeine
    - ❒ Yes ❒ No g. Other _____

15. Are taking any of the following:

If so please list:

				Name	Dosage	Frequency	Date Started
❒ Yes	❒ No	a. Antibiotics or sulfa drugs					
❒ Yes	❒ No	b. Anticoagulants (blood thinners)					
❒ Yes	❒ No	c. Medicine for high blood pressure					
❒ Yes	❒ No	d. Diuretics					
❒ Yes	❒ No	e. Cortizone (steroids)					
❒ Yes	❒ No	f. Tranquilizers					
❒ Yes	❒ No	g. Antihistamines					
❒ Yes	❒ No	h. Aspirin					
❒ Yes	❒ No	i. Insulin					
❒ Yes	❒ No	j. Thyroid medication					
❒ Yes	❒ No	k. Digitalis					
❒ Yes	❒ No	l. Nitroglycerin					
❒ Yes	❒ No	m. Other drugs for heart conditions					
❒ Yes	❒ No	n. Weight control medication					
❒ Yes	❒ No	o. Immunosuppressants					
❒ Yes	❒ No	p. Others					

16. Are you taking any over the counter or unprescribed medication? If so, please list.

❒ Yes ❒ No

_____

_____

17. WOMEN

❒ Yes ❒ No Are you pregnant?

❒ Yes ❒ No Do you have any problems associated with your menstrual cycle?

❒ Yes ❒ No Do you have any children? How many? _____

❒ Yes ❒ No Are you taking birth control pills?

PATIENT DENTAL HISTORY

What is the reason for this initial visit? _____

What are your dental complaints at this time? _____

_____

When was your last visit to the dentist? _____

When were your last dental x-rays taken? _____

When was your last cleaning? _____

Is there any condition or previous difficulty with dental treatment that your dentist should know about before undertaking treatment? If so please explain:

_____

_____

REFERRAL: Whom may we thank for referring you to our office? _____

CONSENT:

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor employ such assistance as deemed fit to provide recommended treatment.

Signature _____ Date _____

CUMMING'S FAMILY DENTIST

Ann Ullah, DDS

PATIENT CONSENT FORM

I understand that under the **Health Insurance Portability and Accountability Act** (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and dentist/physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Signature Printed Name Date

Relationship to Patient (if applicable)

Broken Appointment Fees

Your time is important to us, and it is our goal that patients never wait more than 15 minutes to be seen by the dentist or hygienist. It is also our goal to make appointments available within a week, in order to prevent small problems from turning into larger ones. To help us achieve the best treatment for everyone we do not "double book".

This means that your dentist or hygienist will be able to give you their full attention.

Missed appointments or those cancelled with short notice are a huge problem in the dental field. Unfortunately, this results in higher fees in general, throughout the industry. Our fee structure in this office is designed to be very reasonable and we are pleased to offer care credit and payment options that benefit our valued patients.

In order to provide prompt dental care with reasonable fees and additional discounts we do charge for appointments that are **missed or cancelled with less than 24 hour's notice.**

The fee structure for missed appointments and those cancelled with less than 24 hour's notice is as follows:

HYGIENIST'S SCHEDULE

Cleaning appointment: $50

Scaling and root planning appointment: $125

DENTIST'S SCHEDULE

Minor services (Filling, etc.): $80

Major services (Crown,RCT, etc.): $160

We understand that people with difficult work schedules, frequent illnesses, busy children, and dental phobias miss appointments more often than the general population. If you fall into one of those categories we ask that you fully understand and agree with this policy before becoming one of our patients.

Obviously there are dire emergencies and highly unusual circumstances that will be excluded, with documentation.

I have read this policy and understand it: _____

Date:_____

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For your convenience, we offer 2 forms of payment arrangements.

Option #1: I prefer to pay in full at the time of my dental services. My dental claim will be filed as a courtesy. My dental insurance company will be directed to send the payment to me. I understand that most insurance companies now accept electronic filing and that if I have not received my check within 2 weeks, I should contact my insurance company.

Option #2: I prefer to pay the *ESTIMATED* co-payment and allow my insurance company to evaluate the remaining balance. I understand that I will be given a courtesy of up to 45 days for my insurance to respond. I understand that once my insurance company has evaluated and paid/ or denied my claim, I will be responsible for any remaining balance, and authorize the credit card listed below for that balance.

Card Number_____

Exp _____Code_____

I select Option# _____

*Any unpaid balance over 60 days will be financed at 1.5 % per month.

I will be responsible for any attorney's fees and/or collection charges incurred should my account become delinquent due to non-payment.

Signature _____Date_____