
## MEDICAL HISTORY FORM

Date:_____

Patient Name: _____ Preferred Name:_____
DOB: _____ Sex: _____ Married:_____ Single: _____ Child:_____
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____ Cell: _____
E-mail: _____ Social Security #: _____
Employer/Occupation: _____
Emergency Contact: _____ Phone #: _____ Relationship:_____
How would you like to be contacted Rate 1, 2, and 3 Call___ Text___ Email___

### PRIMARY INSURANCE INFORMATION

Name of Subscriber:_____ DOB:_____ Insurance Carrier:_____
Group #: _____ Subscriber ID: _____
Insurance Address: _____ City:_____ State: _____ Zip:_____
Patient Relationship: _____

### SECONDARY INSURANCE INFORMATION

Name of Subscriber:_____ DOB:_____ Insurance Carrier:_____
Group #: _____ Subscriber ID: _____
Insurance Address: _____ City:_____ State: _____ Zip:_____
Patient Relationship: _____

**Referred to us by:** _____

**Please check the conditions that apply to your present or past medical status:**

___ AIDS/HIV
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Cancer: _____
___ Cardiovascular Disease
___ COPD/Emphysema
___ Diabetes Type I or II
___ Difficulty Breathing
___ Dizziness
___ Drug/Alcohol Abuse
___ Epilepsy/Seizures
___ Excessive Bleeding
___ Fainting
___ Glaucoma
___ Hay Fever
___ Head Injuries
___ Heart Disease
___ Heart Murmur
___ Heart Attack
___ Hepatitis: A B C
___ High Blood Pressure
___ High Cholesterol
___ Hypo/Hyper Thyroid
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pacemaker/Stent
___ Pregnancy
___ Respiratory Problems
___ Radiation/Chemotherapy
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Smoking/Tobacco
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease

**RATE YOUR SMILE:** 1 2 3 4 5 6 7 8 9 10 WITH ONE BEING THE LEAST HAPPY AND 10 BEING VERY HAPPY

If you had a magic wand, what if anything would you change about your smile? _____

Do you have any special events coming up? _____

What is your goal for your mouth and smile? _____

Do you have any allergies to medications? Yes No
If yes, please explain:_____

Do you require any pre-medications prior to dental treatment? Yes No
If yes, for what:_____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
Please explain:_____

Are you under the care of a physician? Yes No
Physician's name and number _____
If yes, what condition being treated? _____

Are you taking any medicine(s) including non-prescription medicine, drugs or alcohol? Yes No
If yes, what medicine(s) are you taking?_____

Have you been admitted to a hospital or needed emergency care during the past five years? Yes No
If yes, Please explain:_____

Have you ever had any complications following dental treatment? Yes No
If yes, please explain:_____

Are you wearing removable dental appliances? Yes No

## CONSENT FOR SERVICES

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Shaylar Hatch or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this medical history form.

I give my consent for dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I have been advised of all probable complications of the dental treatment.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

I understand that I am financially responsible for dental fees, with or without insurance payment.

I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits or services.

**Signature of Patient or Parent if minor** _____ **Date**_____

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

Dr. Shaylar Hatch is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You have the right to review our privacy practices; the right to access any health information or amendments made to it. You also have the right to an accounting of disclosures and restrict uses of communicating health information. If you have any questions concerning this Notice please call us at
480-525-6000

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may use and disclose health information about you for treatment, payment, and health care operations with a family member, your personal representative or another person responsible for your care (which does include communication with dental specialists or physician).

- We may use or disclose your health information to obtain payment for services we provide for you.
- We may use or disclose your health information when we are required to do so by law.
- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.
- We will not use or disclose your health information for any reason other than those listed without your written authorization.
- We may use or disclose your health information to provide you with appointment reminders (such as voicemail and answering machines messages, postcards or letters).

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purposes. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

I have read and understand Dr. Shaylar Hatch privacy practices. I consent for Dr. Shaylar Hatch to disclose my protected information as described. I acknowledge receipt of the Notice of privacy practices.

_____ _____
Signature of Patient or Guardian Date

# Appointments & Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours notice. This makes it possible to give your reserved room to another patient who would like it.
**There is a $50.00 (per hour) charge for not showing up for scheduled appointments.** Repeated cancellations or missed appointments will result in loss of future appointment privileges.
We believe that our patient's time is valuable. When your appointment is made, a room is reserved, your record prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Responsible Party _____ Date _____
(Signature)