

ZIEGELE

Aesthetic & Restorative Dentistry

Last Name	First Name	Middle Initial	Preferred
Male/Female	Child	Single	Married
Divorced			
Date of Birth			
Social Security Number		Spouses Social Security Number	
Address		City	State
		Zip code	
E-Mail			
Home Phone	Work Phone	Cell Phone	
Name of your dental insurance company			
Group No.		ID No.	
Employed by	Business Phone	City	State
		Zip Code	
Spouse Employed by	Phone	City	State
		Zip Code	

We will use and communicate your **HEALTH INFORMATION** only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

MEDICAL HISTORY

(Please check Yes or No and fill-in as necessary.)

		YES	NO			YES	NO
Are you in good health now?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you ever had any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tire easily.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Name _____ Phone# _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized or had a serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Are you pregnant? If so, give due date.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco in any form? If yes, how much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcoholic beverages (more than 2 drinks per day)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, or Guardian _____ Date _____

**Protecting Your
Confidential Health Information
is Important to us**

DO YOU HAVE OR YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

(Please check any of the following which you have had or have at present.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Aids |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Cough | <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Drug Addition |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease (Syphilis
Gonorrhea) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> X-ray or Cobalt Treatment | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pain in Jaw Joints | |

Please note any other diseases not listed _____

Are you ALLERGIC or have you ever experienced any reaction to the following?

- | | YES | NO |
|--|--------------------------|--------------------------|
| Local anesthetics (e.g., novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| List type _____ | | |
| Painkillers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| List type _____ | | |

Others (please list) _____

are you taking any medications: (Please list name, dosage, and reason) _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, or Guardian _____ Date _____

Notice of Privacy Practices

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?

Why a privacy policy now?

Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

Signature _____ I have read the privacy policy.