Confidential Health History Information

Patient Name: ________________________________ Initial Date: ______________________

Updated: ____

Updated: ____

Personal Health Information

Primary Care Physician Name: ____

Primary Care Physician Address: ____

Please answer the following questions to the best of your ability:

Have you been hospitalized within the past 2 years? Yes ☐ No ☐ If yes, for what? ______________________________ ____________________________________ Are you currently being treated by a physician? Yes ☐ No ☐ If yes, for what? ______________________________ Are you currently taking and medicines or drugs? Yes ☐ No ☐ What? ____________________________________ Have you ever received counseling for excessive use of alcohol and/or prescription drugs? Yes ☐ No ☐ Are you allergic to any drugs? Yes ☐ No ☐ If yes, what? __________________________________ Have you ever had a skin rash or other reaction to metal jewelry? Yes ☐ No What? ____________________________________ Do you bleed excessively upon injury? Yes ☐ No ☐ Are you pregnant? Yes ☐ No ☐ Have you ever been involved with dental/medical legal activity? Yes ☐ No ☐	**Please Check Any of the Following Conditions That You Have Had in the Past or Now Have:** ☐ AIDS ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Heart Murmur ☐ Heart Problem ☐ Hepatitis ☐ High Blood Pressure ☐ Jaundice ☐ Kidney Problems ☐ Low Blood Pressure ☐ Nervous Breakdown Or Psychiatric Therapy ☐ Osteoporosis ☐ Rheumatic Fever ☐ Sexually Transmitted Diseases ☐ Stroke ☐ Tuberculosis ☐ Other Diseases ________________ ________________ ________________

Person to Be Contacted in Case of Emergency

Name: ____

Address: ____

Telephone: (Home) ____________________________ (Work) __________________________

Confidential Patient Information

Date: ___________________________

PERSONAL INFORMATION

Name: ______________________________________ SS #:_____________________________

Address: ____

City: ______________________________________ State: _________ Zip: ________________

Telephone: (Home) ____________________________ (Work) ___________________________

(Cell) ________________________ E-mail: _______________________________

Birth Date: __________ Sex: _____ Marital Status: ____________ Spouse Name: __________

Occupation: _____________________________ Referred by: ____________________________

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Name: _______________________________________ SS #: ___________________________

Relationship to Patient: ____________________________ Birth Date: ___________________

Address: ____

City: _________________________________ State: ___________________ Zip: __________

Telephone: (Home) _____________________________ (Work) _________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co: ______________________________ Policy #: ____________________

Group #: _____________ Subscriber Name: ____

SS #: ______________________ Relationship: __________________ Birth date: ___________

Secondary Insurance Co: ____________________________ Policy #: ____________________

Group #: _____________ Subscriber Name: ____

SS #: ______________________ Relationship: __________________ Birth date: ___________

I understand that payment is my obligation regardless of insurance or any other third-party agreement.

____ _____________________

Patient/Guardian Signature Date

Salem Dental

2510 12th St. SE, Salem, OR 97302 – (503) 378-1212

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

***** You May Refuse to Sign This Acknowledgement*****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____ ____________________
{Signature} {Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ___________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}	{Relationship}
{Please Print Name}	{Relationship}
{Please Print Name}	{Relationship}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

____

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Smile Evaluation (Optional)

Do you like your smile? Yes □ No □ If no, and you could change anything about your smile, what would you change? ____
Are you happy with the color of your teeth? Yes □ No □
Would you like your teeth to be whiter? Yes □ No □
Would you like your teeth to be straighter? Yes □ No □
Do you have spaces between your teeth that you would like closed? Yes □ No □
Would you like your teeth to be longer? Yes □ No □
Do you like the shape of your teeth? Yes □ No □ Explain: ____
Do you have missing teeth that you would like replaced? Yes □ No □ Explain: ____
Do you have old silver fillings that you would like replaced with tooth-colored fillings? Yes □ No □
Would there be any reason not to go ahead with any needed dental treatment? Yes □ No □ Explain: ____
What makes you most comfortable in a dental practice? What can we do to achieve this? Explain: ____
What makes you least comfortable in a dental practice? Explain: ____