PATIENT MEDICAL HISTORY

Patient's Name: | **Preferred Name to be called:**

Address: | **Today's Date** | **Emergency Contact Phone Number:**

City State & Zip: | **Email:**

Home Phone: | **Cell Phone:** | **Age:** | **Birth Date:** | **Marital Status:** | **Social Security Number:**

Work Name: | **Work Phone:** | **Pharmacy Name:** | **Pharmacy Phone:**

Referring Dentist/Other: | **Office Phone:** | **General Dentist:** | **Office Phone:**

Physician Name: | **Physician Phone:** | **Dental Insurance Company**

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks: ☐
☐	☐	Are you nursing?

Please answer the following:

Do you smoke or use tobacco?

Y ☐ N ☐

If yes, how long?

If yes, how much per day?

Height:

Weight:

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Medical Alerts:

Y	N	**Conditions**
☐	☐	Rheumatic Fever
☐	☐	Heart Murmur
☐	☐	Angina Pectoris
☐	☐	Congenital Heart Defect
☐	☐	Artificial Heart Valve
☐	☐	Mitral Valve Prolapse
☐	☐	High/Low Blood Pressure
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Digestive/Gastric Problems
☐	☐	Ulcers/Colitis
☐	☐	Heart Attack/Surgery Or Pacemaker
☐	☐	Diabetes
☐	☐	Kidney Problems
☐	☐	Liver Disease Or Yellow Jaundice
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Blood Transfusion
☐	☐	Hemophilia
☐	☐	HIV+ AIDS
☐	☐	Hepatitis A Or B Or C

Y	N	**Conditions**
☐	☐	Epilepsy Or Seizures
☐	☐	Psychiatric Treatment
☐	☐	Drug Or Alcohol Abuse
☐	☐	Cancer/Chemotherapy/Radiation
☐	☐	Shingles
☐	☐	Hay Fever/Sinus Problems
☐	☐	Asthma
☐	☐	Difficulty Breathing
☐	☐	Emphysema Or Tuberculosis
☐	☐	Experienced Excessive Thirst
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Thyroid Problems
☐	☐	Venereal Disease
☐	☐	Glaucoma
☐	☐	Blisters, Cold Sores, Or Mouth Ulcers
☐	☐	Taken or Take Bone Density Meds
☐	☐	Past Smoker/Tobacco Use
☐	☐	Bruise Easily
☐	☐	Fear Dental Treatment
☐	☐	Bleeding/Abcessed Gums
☐	☐	Clench Or Grind Teeth

Y	N	**Conditions**
☐	☐	Sore or Popping Jaw Joints
☐	☐	Satisfied W/Appearance of Teeth
☐	☐	Frequently Awaken W/Sore Jaws
☐	☐	Teeth Cleaned in Last Year
☐	☐	Past Gum Trouble Or Treatment
☐	☐	Had Instruction On Plaque Control

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below…**

Notes:

Signature: _____ **Date:** _____

Dental Plan/Insurance Benefits

Primary Insurance Company _____

Insurance Company Address _____

_____

Insurance Company Phone # _____

Primary Policy Holder _____

Place of Employment of Primary Policy Holder _____

Primary Policy Holder Date of Birth _____

Primary Policy Holder Social Security # _____

Policy ID# _____ Group # _____

Patient Relationship to Primary Policy Holder _____

HIPAA PRIVACY FORM

Acknowledgement of Receipt 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

****** Please fill out this portion only.**

_____
{Signature}

_____
{Date}

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Consent for Use and Disclosure of Health Information

USE OF THIS FORM IS OPTIONAL

Purpose: In cases where Dr. Lee Ann Hovious has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

Dr. Lee Ann Hovious 10265-B Kingston Pike Knoxville, TN 37922

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ **E-mail:** _____

Patient Number: _____ **Social Security Number:** _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

***** **Please fill out the portion between the arrows.**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gina Holt

Telephone: (865) 539-1113 Fax: (865) 539-0576

Address: 10265-B Kingston Pike, Knoxville, TN 37922

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____