medical history

Opalesque

Keiko Wada, DMD

Patient's Name _____ Birthdate _____

Home Phone: _____ Work _____ Cell _____

Email (for confirming visit) _____

Physician's Name _____ Phone _____

Are you in good health? ❍ Yes ❍ No

Have you been hospitalized in the last two years? _____

If yes, please explain _____

_____

Please list all current medications along with reasons for taking them:

1. _____
2. _____
3. _____
4. _____

Have you ever had an adverse or allergic reaction to medication? ❍ Yes ❍ No

If yes, please explain _____

Do you have an artificial prosthesis, such as prosthetic heart valve, pulmonary shunt or conduit, artificial joint, pacemaker, port or stent? ❍ Yes ❍ No

If yes, when was it placed? Please explain _____

_____

Have you had an organ transplant? ❍ Yes ❍ No

Do you have mitral valve prolapse with regurgitation? ❍ Yes ❍ No

Have you ever been told to premedicate with antibiotics prior to dental tx? ❍ Yes ❍ No

Why? _____

Have you ever been treated for the following: (circle all that apply)

AIDS	alcoholism	asthma
cancer	diabetes	eye disorder
heart condition	hemophilia	hepatitis
kidney disease	liver disease	rheumatic fever
stroke	tuberculosis	

If yes, please explain _____

_____

If you have had cancer, did therapy include chemotherapy or radiation? ❍ Yes ❍ No

Have you ever taken a medication to improve bone density? ❍ Yes ❍ No

Have you ever taken medication for weight loss, such as Fen-Phen? ❍ Yes ❍ No

If yes, are there any heart complications? Please explain _____

_____

Are you pregnant? ❍ Yes ❍ No

Comments on your health: _____

_____

Patient/Parent Signature (if patient is a child)

_____ Date _____

Thank you for completing this form and allowing us to better serve your dental health.

dental history

Opalesque

Keiko Wada, DMD

Patient's Name _____ Birthdate _____

Parent/Guardian (for minors) _____

What is your primary reason for visiting our office today? _____

_____

When was the approximate date of your last dental appointment? _____

_____

Have you been satisfied with your past dentistry? Yes No

If no, please explain _____

Has any concern of discomfort prevented you from regular dental care? Yes No

If you would like x-rays requested from another dentist, please provide the information below:

Dentist's Name _____

Address _____

Reason for leaving _____

How many times daily do you brush your teeth?_____ If electric, which brand? _____

How many times daily do you floss your teeth?_____ ❍ Yes ❍ No

Do you gag easily during dental visits? ❍ Yes ❍ No

Is your mouth often dry? ❍ Yes ❍ No

Have you had orthodontitic treatment? (braces?) ❍ Yes ❍ No

Do you wear an orthodontic retainer? ❍ Yes ❍ No

Have you had periodontal (gum) treatment(s)? ❍ Yes ❍ No

Do your gums bleed easily and/or feel tender? ❍ Yes ❍ No

Do you get headaches? ❍ Yes ❍ No

Do you have problems with teeth or fillings breaking? ❍ Yes ❍ No

Are your teeth sensitive to pressure? ❍ Yes ❍ No

Are your teeth sensitive to temperature? ❍ Yes ❍ No

Are your teeth sensitive to sweets? ❍ Yes ❍ No

Do you have any clicking or popping in your jaw joints? ❍ Yes ❍ No

Do you have pain in your jaw joints? ❍ Yes ❍ No

Are you aware or have been told that you grind or clench your teeth? ❍ Yes ❍ No

If yes, do you wear a bite guard? ❍ Yes ❍ No

Are you pleased with the appearance of your teeth? ❍ Yes ❍ No

If no, please explain _____

Is there any additional comments or concerns you have regarding your dental history or care?

_____

_____

Patient/Parent Signature (if patient is a child)

_____ Date _____

Thank you giving us the opportunity to provide comprehensive dental care for you.

patient billing information

Patient's Name _____ Birthdate _____

Mailing Address _____

City/State _____ Zip _____

Home Phone: _____ Work _____ Cell _____

Email (for confirming appointments) _____

Person Responsible for the Account _____ SS# _____

Opalesque

Keiko Wada, DMD

Primary Insurance Co. _____

Subscriber _____

Subscriber ID _____ Birthdate _____

Employer _____

Insurance Address _____

City/State _____ Zip _____

Group Number _____

Secondary Insurance Co. _____

Subscriber _____

Subscriber ID _____ Birthdate _____

Employer _____

Insurance Address _____

City/State _____ Zip _____

Group Number _____

I understand that responsibility for payment for Dental Services provided in the office of **Keiko Wada, DMD** for myself or my dependent is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign benefits to the Doctor.

Patient/Parent Signature (if patient is a child)

_____ Date _____

Thank you for the opportunity to serve your dental needs.

acknowledgement of privacy practices

Keiko Wada, DMD

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of *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 health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I**n addition to the allowable disclosures described in the Statement of Privacy Practices,** I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO." Without indicating "Yes" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

- Spouse only ❍ Yes ❍ No
- *Or* Any member of my immediate family *(i.e. Spouse, Children, Siblings, etc.)* ❍ Yes ❍ No
- *Or* Any member of my extended family (*i.e. Parents, Grandchildren*) ❍ Yes ❍ No
- *Or* Other (*please print name and relationship*) ❍ Yes ❍ No

Patient's Name (*please print*) _____ Date _____

Patient/Parent Signature *(if patient is a child)* _____

Patient's Personal Representative (*please print*) _____

Personal Representative Signature _____

for office use only

Acknowledgement was not obtained of our *Notice of Privacy Practices.*

Provided prior to treatment? ❍ Yes ❍ No Date (*statement provided*) _____

Reason for not obtaining signature:

- ❍ Needed more time to review Statement
- ❍ Wanted to consult another person before signing
- ❍ Physically unable to sign
- ❍ No reason offered
- ❍ Other

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