

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last physical \_\_\_\_\_

**Place a mark on "yes" or "no" to**

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head/neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Popping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limited Opening	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congested Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ringings Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Posture Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bell's palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you use tobacco products?

Yes No If yes, what and how often, how long

Do you use antidepressants or sleeping pills?

Yes No if yes, list name(s)

**Do you or your Spouse have the following?**

Sleep Apnea Yes No Do you Snore? Yes No

Have you had sleep studies? Yes No

(CPAP) Yes No Do you use your CPAP? Yes No

Are you on any blood thinners, including aspirin?

Yes mg \_\_\_\_\_ No

Have you ever seen an ENT (ear, nose and throat doctor)?

Yes No Name: \_\_\_\_\_

Have you seen a chiropractor?

Yes No Name: \_\_\_\_\_

Have you seen a neurologist?

Yes No Name: \_\_\_\_\_

Have you had braces?

Yes No Name: \_\_\_\_\_

Do you have massage therapy regularly?

Yes No Name: \_\_\_\_\_

Are you pregnant? Yes No

If yes when is your due date? \_\_\_\_\_

Taking birth control pills? Yes No

Are you taking hormones? Yes No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis \_\_\_\_\_

Vitamins/Minerals Herbs

Pharmacy Name \_\_\_\_\_

## ALLERGIES

Aspirin  Local Anesthetic

Barbiturates (sleeping pills)  Penicillin

Codeine  Sulfa

Iodine  Other \_\_\_\_\_

Latex

None



## DENTAL INTERVIEW

Choto Family Dentistry is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability.....thank you!

- What is the main purpose of your first visit and what would you like to get accomplished? \_\_\_\_\_  
\_\_\_\_\_
- Briefly mention any positive or negative aspects of your previous dental visits: \_\_\_\_\_  
\_\_\_\_\_
- What do you already know about our office and what are your expectations? \_\_\_\_\_  
\_\_\_\_\_

### **Treatment Recommendations or Treatment Options?**

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you..... please rate on the following scale from 10 to 1.

1. How (dental) healthy would you like to be?

←----->  
10 (healthiest)                      1 (not a concern at this time)

2. Almost all dental problems are predictable and preventable....in order to not overwhelm you with excess details, How preventive (or proactive) would you like to be regarding dental disease?

←----->  
10 ("nip it in the bud early")                      1 (wait until it hurts)

3. How important are dental cosmetics to you?

←----->  
10 (very important)                      1 (not important)

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.

How important is facial cosmetics to you?

←----->  
10 (very important)                      1 (not important)

Anything else you would like to mention? \_\_\_\_\_



## NEW PATIENT MENU OF SERVICES

Our office offers a diverse array of dental services. To help us better understand your needs and desires please check which of the following services in which you are interested.

### Cosmetic Services

- Smile Makeover
- Porcelain Veneers
- Full Mouth Rejuvenation
- Non-Surgical Facelift Dentistry
- Replacing Old Fillings
- Cosmetic Dentures
- Teeth Whitening

### Examination Services

- Comprehensive Examination
- Personalized Lifetime Dental Plan
- Teeth Cleaning & Maintenance

### Discomfort / Pain

- Tooth Pain Relief
- Jaw Pain Relief
- Chronic Headache Treatment
- Migraine Treatment

### Consultative Services

Consultation about: \_\_\_\_\_

2<sup>nd</sup> Opinion about: \_\_\_\_\_

### Specialized Services

- Sedation Dentistry
- Dental Implant
- Myofunctional Therapy  
(Oral Habit Therapy)
- Custom Facelift Dentures

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## PATIENT INFORMATION

Date \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 Wished to be called \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Married  Widowed  Single  
 Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 \_\_\_\_\_  
 Employer Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 How did you hear about our office?  
 \_\_\_\_\_

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## INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 ID# \_\_\_\_\_

Is there any additional dental insurance? \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 ID# \_\_\_\_\_  
 Is Patient covered by medical insurance? \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_  
 Subscriber's ID or SSN \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 ID# \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I understand that Choto Family Dentistry participates with multiple dental insurance companies and does not participate with all insurance companies, but will accept the payment from my insurance company towards the dental services that are needed to obtain a healthy mouth. Choto Family Dentistry may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

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## CONTACT INFORMATION

Home ( ) \_\_\_\_\_  
 Work ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_  
Used for confirming appointments  
 E-mail Address \_\_\_\_\_  
Used for confirming appointments

### IN CASE OF AN EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_



# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

## 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.

**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: **Sara Berry**  
**Choto Family Dentistry**

**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.

### SIGNATURE

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 health 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: \_\_\_\_\_

### REVOCAION 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: \_\_\_\_\_