



# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Why are you now seeking dental treatment? \_\_\_\_\_

Please answer each question. Check yes or no. If in doubt, leave blank.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of a physician? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____  |                          |                          |
| 3. Have you ever been hospitalized or had a serious illness?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____  |                          |                          |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Women) Are you pregnant? If so, give due date _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any of the following?  |                          |                          |

- | GENERAL                                  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Tire easily, weakness .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>SKIN</b>                              |                          |                          |
| Eruptions (rash) hives .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in skin color .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EYES</b>                              |                          |                          |
| Visual change .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EARS</b>                              |                          |                          |
| Loss of hearing .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>NOSE</b>                              |                          |                          |
| Frequent nosebleeds.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>THROAT</b>                            |                          |                          |
| Soreness/hoarseness .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>NERVOUS SYSTEM</b>                    |                          |                          |
| Stroke .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/epilepsy .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/tingling.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/fainting .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>RESPIRATORY</b>                       |                          |                          |
| Tuberculosis .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/hay fever.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum production (phlegm).....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough up bloody sputum .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down .. | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ENDOCRINE</b>                         |                          |                          |
| Diabetes .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid condition/goiter.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                              | <input type="checkbox"/> | <input type="checkbox"/> |

- | HEART/BLOOD VESSELS                                 | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Rheumatic fever .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/discomfort .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/trouble.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>BONE/MUSCLES</b>                                 |                          |                          |
| Arthritis/rheumatism .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints/limbs.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>DIGESTIVE SYSTEM</b>                             |                          |                          |
| Hepatitis .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Black, bloody or pale stools .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>URINARY</b>                                      |                          |                          |
| Kidney disease .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Increase in frequency<br>of urination (night) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning on urination .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral discharge.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>BLOOD</b>  |                          |                          |
| Bruise easily .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>OTHER</b>  |                          |                          |
| Latex sensitivity .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation therapy .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors or growths.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Cancer</b> .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV+ .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorder .....                               | <input type="checkbox"/> | <input type="checkbox"/> |

Please complete reverse side

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

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine) ....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine .....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills ..	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies .....		

10. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners .....	<input type="checkbox"/>	<input type="checkbox"/>	Herbal supplements .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication .....	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medication .....	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids .....	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications.....	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/.....	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, list name of medication and dosage below:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_

12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

13. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_

14. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_

15. Date of last dental visit \_\_\_\_\_

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_  
If so, when? \_\_\_\_\_

17. Do you have or have you ever had any of the following?

**MOUTH**

	YES	NO
Bleeding, sore gums .....	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips .....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatments (braces).....	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw .....	<input type="checkbox"/>	<input type="checkbox"/>

**MOUTH**

	YES	NO
Loose teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to hot .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cold .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to sweets .....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to biting .....	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction .....	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding .....	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite.....	<input type="checkbox"/>	<input type="checkbox"/>

**ORAL HYGIENE**

Do you use the following?	YES	NO
Brush.....	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss .....	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse .....	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush? \_\_\_\_\_  
Brush is: Soft  Medium  Hard

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 \_\_\_\_\_ Date \_\_\_\_\_  
Parent, or Guardian \_\_\_\_\_

**Consent to the Use and Disclosure of Health Information for  
Treatment, Payment or Healthcare Operations**

**K. CLAY ELLIS, JR., DMD, LLC**

I understand that as part of my dental care, K. Clay Ellis, Jr., DMD originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among other health professionals who contribute to my care
- A source of information for applying my treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine dental care operations such as quality assessment and improvement activities

I understand and 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 to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that K. Clay Ellis, Jr. is not required to agree to the restrictions requested. I understand that I may revoke this restriction in writing, except to the extent that K. Clay Ellis has already taken action in reliance thereon.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

**Acknowledgement of Receipt of Notice of Privacy Practices**

**K. Clay Ellis, Jr., DMD, LLC**

\*You may refuse to sign this acknowledgement\*

By signing this form I acknowledge that I have been provided with this office's Notice of Privacy Practices to review, and informed that I may keep a copy for reference or obtain a copy upon request.

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

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

**For Office Use Only:**

We attempted to obtain written acknowledgement, but it could not be obtained because:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other \_\_\_\_\_

**K. CLAY ELLIS, JR., DMD, LLC**

**Patient Financial and Insurance Agreement**

Welcome to our office. We are honored that you have chosen us as your dental health care provider.

Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract for insurance benefits exists between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office.

1. All payments are due at the time service is rendered. We accept payment for services by cash, check, debit, MasterCard, Visa, American Express, Discover, and Care Credit.
2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
3. If your insurance does not cover 100% of the charges, you are responsible for the non-covered balance. You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.
4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated co-payment and deductible be paid at the time of service. We may require a deposit at the time of appointment for some services that cost more than \$200. Our office will let you know of any required deposit in advance. We will file insurance claims and accept assignment of benefits. After receiving payment through your insurance, we will send a statement with any balances due. We ask that payment be made within 14 days of the statement.
5. If you do not have insurance, or your insurance reimburses you, or you are over your insurance limit, payment in full is expected at the time of service unless arrangements have been made in writing prior to treatment.
6. Fees quoted will be accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes prior to the procedure.
7. In the event of default of payment or after 90 days, a service charge of 1.5 percent per month will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.
8. Our office requires a 24-hour notice for any cancelled appointments. A fee of \$50 may be assessed for canceling an appointment without 24-hour notice.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask—we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

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PRINT Patient Name

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Signature of Patient or Parent if Minor

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Date

## Disclosure of Protected Health Information - PRIVACY

*{Sharing Protected Health Information with Family and Friends}*

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I am authorizing **K. Clay Ellis, Jr., DMD, and staff** to discuss my medical information with the following individuals:

Name - PLEASE PRINT	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**\*OR** Do **not** disclose medical information to anyone other than myself \_\_\_\_\_ (initials)

Besides calling me on my personal phone numbers or mailing correspondence to my home, this authorization also allows Dr. Ellis or his staff to do the following:

- Call me at work
- Leave messages on an answering machine or voice mail
- Send Text messages
- Email appointment reminders or other correspondence
- Discuss appointments & account with the above individuals

This remains in effect until I give written notification to change it or discontinue it.

\_\_\_\_\_  
Signature of Patient or Legal Representative:

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

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### As Required by Federal Law:

I certify I am who I claim to be.

I have provided documentation supporting claims and my information was verified by: \_\_\_\_\_

It will be my responsibility to inform of any changes in my personal information upon future visits.

\_\_\_\_\_  
Signature of Patient or Legal Representative:

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

**FOR OFFICE USE ONLY**

I have followed regulations in obtaining, verifying, and recording this patient's identification.

Staff Signature: \_\_\_\_\_

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