.DENTISTRY.

KEVIN J. WENDELL, DDS

• HEALTHY HABITS FOR LIFE •

Date: _____

Patient Information:

Name_____ Prefers to be Called_____

Address_____ Mailing Address_____

Town_____ State_____ Zip_____ Marital Status_____

Primary Phone_____ Secondary Phone_____

Email_____ D.O.B. _____

Employer_____ Work Phone_____

EMERGENCY CONTACT: Name_____Phone_____

Responsible Party: (if different from above)

Name_____ Address_____D.O.B_____

Dental Insurance Information: check if does not apply ____

Name of person carrying insurance_____Insurance Company_____

Insurance ID # **or** social security #_____ Insured's D.O.B_____

Group Number_____ Insured employer name_____

Do you have another dental insurance?_____

Medical History:

Physician's Name_____ Date last visit (approx.) _____

Additional Specialist doctors:_____ Date of last visit_____

Please circle Y (yes) or N (no) for ALL medical conditions listed below:

Y or N Aids/HIV	Y or N Jaundice	Y or N Blood Disease	Y or N Ulcers
Y or N Cortisone Treatments	Y or N Sinus Trouble	Y or N Glaucoma	Y or N Anemia
Y or N Heart Problems	Y or N Artificial pins, joints	Y or N Mitral Valve Prolapse	Y or N Epilepsy
Y or N Respiratory Disease	Y or N Diabetes	Y or N Cancer	Y or N Skin Rash
Y or N Kidney Disease	Y or N Thyroid Problems	Y or N Tumors or growths	Y or N Arthritis
Y or N Circulatory Problems	Y or N Stroke	Y or N Radiation Treatment	Y or N Liver Disease
Y or N Hepatitis (type____)	Y or N Asthma	Y or N Pacemaker	Y or N Venereal Disease
Y or N Rheumatic Fever	Y or N Headaches	Y or N Scarlet Fever	Y or N Fainting/dizziness
Y or N Chemical Dependency	Y or N Abnormal Bleeding	Y or N Persistent cough	Y or N Heart Murmur
Y or N High Blood Pressure	Y or N Low Blood Pressure	Y or N Artificial Heart Valves	
Y or N Congenital Heart Lesions	Y or N Swollen neck glands	Y or N Weight Loss, unexplained	

Allergies: Do you have an allergy to any of the following, OR medication not listed? Please circle any that apply

Latex	Aspirin	Barbituates (sleeping pills)
Penicillin	Codeine	Iodine
Sulfa	Local Anesthetic	Other_____

Please List **ALL** medications you are taking, the amount and frequency for each: _____

_____

SIGNATURES: PATIENT or guardian _____ ___/___/___ **DOCTOR/R.D.H**_____ ___/___/___

Patient Name_____ **Date**_____

Please answer the following questions:

Would you like to keep all of your teeth all of your life?	Y or N
Have you ever taken pre-medication (antibiotics) before dental visits?	Y or N
Have you had any periodontal treatment (gum treatment) in the past?	Y or N
Do you take Aspirin (Bayer, Bufferin) on a regular basis?	Y or N
Have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel)?	Y or N
Have you ever taken any group of drugs that are affiliated with Fen-phen?	Y or N
Have you ever been diagnosed with a problem with either jaw joint?	Y or N
Does your jaw click, pop, or make noise when you open and close?	Y or N
Is there pain or tenderness in your jaw joint when you open, close or chew?	Y or N
Has your jaw ever locked open or closed?	Y or N
Do you clench or grind your teeth, or ever been told you do?	Y or N
Have you ever had trauma to your chin or jaw?	Y or N
Do you have frequent headaches? If so how often? _____	Y or N

Women: Are you Pregnant ___ Nursing ____ Taking Birth Control Pills _____

PLEASE CHECK ALL THAT APPLY:

Y or N Bad Breath	Y or N Food collects between teeth	Y or N Pain around ear
Y or N Bleeding gums	Y or N Foreign objects	Y or N Orthodontic Treatment
Y or N Blisters on lips/mouth	Y or N Gums swollen or tender	Y or N Fingernail biting
Y or N Burning on tongue	Y or N Lip or cheek biting	Y or N Sensitivity to Hot/Cold
Y or N Chew on one side of mouth	Y or N Loose teeth/broken fillings	Y or N Sensitivity to Sweets
Y or N Cigarette or Cigar smoking	Y or N Mouth breathing	Y or N Sensitivity when biting
Y or N Dry mouth	Y or N Mouth pain	Y or N Sores in Mouth

New Patients:

Whom may we thank for this referral? (a current patient, Google search, etc)

_____

SIGNATURES: PATIENT or guardian _____ ___/___/___ **DOCTOR/R.D.H**_____ ___/___/___

KEVIN J. WENDELL, DDS

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____