HEALTH HISTORY FORM
FORD DENTAL GROUP

Patient First Name: _____ **Last:** _____ **Middle:** ____ **Date:** _____
Home Address: _____ **City:** _____ **Zip Code:** _____
Social Security Number: ____ / ____ / _____ **Home Phone:** (____) _____-_____ **Cell:** (____) _____-_____
Date of Birth: ____ / ____ / _____ **Sex: Female** ___ **Male** ___ **Email Address:** _____

Emergency Contact Name: _____ **Phone:** (____) _____-_____ **Relationship:** _____

Date of last health care exam: ____ / ____ / _____ **What was this exam for?** _____

Have you been hospitalized or had surgery in the last 12 months? (Please Circle) **No** **Yes**
If yes, reason: _____

Are you currently receiving care? (Please Circle) **No** **Yes** If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

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

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism, or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPS or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication Before Dental Treatment	No	Yes	Biaxin (Clarithromycin)	No	Yes
Antacids	No	Yes	Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Barbiturates (Any)	No	Yes
Dilantin or Tegretol	No	Yes	Diflucan (Fluconazole) or Sporonox (Itranconazole)	No	Yes

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Boniva, RECLAST) or If so, when did the treatment begin? When did the treatment end?	No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?	No	Yes

Please list any medications you are currently taking and dosages including any Blood Thinner Medications:

1.) _____ 5.) _____
2.) _____ 6.) _____
3.) _____ 7.) _____
4.) _____ 8.) _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1.) _____ 5.) _____
2.) _____ 6.) _____
3.) _____ 7.) _____
4.) _____ 8.) _____

Do you use recreational drugs? (Please Circle) **No Yes** If yes, which ones? _____

Sleep: (Please Circle)

1.) Do you suspect or have you been told that you snore? **No Yes**
2.) Do you suspect or have you been diagnosed with sleep apnea? **No Yes**
3.) Are you being treated for sleep apnea with a CPAP, BiPAP, or other device? **No Yes**

Women: Are you pregnant? (Please Circle) **No Yes**
If no, are you planning a pregnancy in the future? **No Yes**
Are you a nursing mother? **No Yes**
Are you taking birth control pills? **No Yes**

Abnormal Blood Pressure? (Please Circle) **No Yes**
Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"? **No Yes**
What is your normal blood pressure? _____S _____D Today: _____ / _____

Are you allergic or have you had a reaction to: (Please Circle)

a.) Local anesthetics or epinephrine ..... **No Yes**
b.) Penicillin or other antibiotics ..... **No Yes**
c.) Aspirin, Ibuprofen or Tylenol® ..... **No Yes**
d.) Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives **No Yes**
e.) Latex or Metals ..... **No Yes**
f.) Other (Please Specify) _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: **Smoke Chew** How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood-altering drugs other than those previously listed?	No	Yes

Weight and Diet Considerations

Weight	Height	Meals Per Day	Dietary Restrictions	Food Allergies

FORD DENTAL GROUP

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medication.

I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form/Health History.

Patient (Print Name)	*Patient Signature*	*Date*
Doctor (Print Name)	*Doctor Signature*	*Date*

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

FORD DENTAL GROUP
16511 Goldenwest St., Suite 107
Huntington Beach, CA 92647

ACCOUNT INFORMATION

PATIENT INFORMATION

Patient's Name:
Address:
City: State: Zip:
Date of Birth: / / Sex: M F Social Security Number:
Home Number: Alternate Number:
E-Mail Address:
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed Drivers license Number:

PERSON RESPONSIBLE FOR PAYING THE BILL - Check here if Same as above [ ]

Name: Relationship - [ ] Spouse/Partner [ ] Parent
Address:
City: State: Zip:
Drivers License number Social Security Number:
Phone Number
E-Mail Address:

INSURANCE INFORMATION

Primary Insurance:

Subscriber/ Policy Holder:
ID Number (or Social Security Number) -
Date of Birth Relationship to Patient: [ ] Self [ ] Spouse [ ] Child
Employer:

Secondary Insurance:

ID Number (or Social Security Number) -
Date of Birth Relationship to Patient: [ ] Self [ ] Spouse [ ] Child
Employer:

RELEASE OF INFORMATION

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your dentist or staff associated with Ford Dental Group todiscuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or ifr you are unable to give youer authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Name: Relationship to Patient:
Name: Relationship to Patient:
Name: Relationship to Patient:
Name: Relationship to Patient:

I certify that I have read and understand the above and that the information given on this form is accurate

X DATE:

Patient / Parent / Guardian / Responsible Party Signature

FORD DENTAL GROUP
5355 WARNER AVENUE
HUNTINGTON BEACH, CA 92649
(714)842-7431

FINANCIAL POLICY

Thank you for choosing our office as your dental care provider. We are committed to your treatment being successful in every way for your overall health and wellbeing. Please understand that payment of your bill is considered part of your treatment.

The following is a statement of your financial policy, which we require you to read and sign prior to any treatment. Should you have any questions about this policy, please feel free to ask our front office team.

Insurance Patients: A treatment plan will be provided to you itemizing your treatment and, "estimated" insurance and patient portions. Patient's estimated portion is due the day services are rendered. We ask our patients to keep in mind that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Responsibility for payment with Ford Dental Group for your treatment lies not with your insurance company, but with you directly. As a courtesy to you, our office will bill your insurance carrier(s), but you are ultimately responsible for all expenses incurred in our office. If your insurance carrier does not remit payment, the balance will be due in full by you. If you wish to re-bill your insurance, you may request a fully itemized statement or copy of the original insurance claim form.

Non-Insured Patients: If you do not have dental insurance coverage, the balance of your treatment will be due and payable at the time of treatment. For our non-insured/cash patients we can offer you our office Membership Club and we will be happy to review this with you at your appointment or you can also obtain this information on our office website: forddentalgroup.com.

Usual and Customary Fees: Our practice is committed to providing you with the best and optimal dental care. Our office charges what is usual and customary for our area. You will be responsible for payment regardless of any insurance company's arbitrary determination of our usual and customary rates.

Minor Patients: The adult accompanying a minor child and or the parents (or legal guardian) of the minor child will be responsible for full payment. For an unaccompanied minor, non- emergency treatment will be denied unless prior arrangements have been made with our office.

Missed Apointments: We ask that you give our office **(48)** hours notice of any appointments you need to cancel or change. Our office will charge: **$150.00** per hour for any broken appointments such as Hygiene (1) hour or Dental treatment per hour of time that is scheduled, missed appointments, appointments not rescheduled and or cancelled within **(48) hours.** For all patients that cancel or fail their appointments and wish to reschedule, a non-refundable **$150.00 deposit** will be required when patient wishes to reschedule to hold that appointment time.

Arriving Late to a Scheduled Appointment: Our office strives to see every patient as close to their appointment time as possible and it is not fair to make other patients wait because another patient was late. If you are an established patient and you arrive **15 minutes late** or more to your appointment you will likely be rescheduled and our office will charge a broken appointment fee of: **$150.00.**

Patient Signature: _____ **Date:** _____