King & Miles Family Dentistry

Medical History Form **Date**_____

Name: _____ Home Phone: (____)_____
Last — First — Middle

Address: _____ Business Phone: (____)_____
Number — Street

City: _____ State: _____ Zip Code: _____E-mail: _____

Occupation: _____ Social Security #: _____

Date of Birth: _____/_____/_____ ◯Male ◯Female Height: _____Weight: _____ ◯Single ◯Married
month day year

Name of Spouse: _____ Emergency Contact: _____Phone: (____)_____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by: _____

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with your oral health and the dental care you will receive. Thank you for answering the following questions. Please circle Yes or No. If you answer yes to any question, please explain.

Are you under a physician's care? Yes No If yes:_____

Have you ever been hospitalized or had a major operation? Yes No If yes: _____

Have you ever had a serious head or neck injury? Yes No If yes: _____

Are you taking any prescriptions or over-the-counter medications? Yes No If yes, please list below:

Do you take anti-coagulant medications (blood thinners)? Yes No If yes:_____

Have you ever had joint replacement, heart valve replacement or a congenital heart defect? Yes No

Are you required to take premedication (antibiotics) for any condition such as joint replacement or a heart condition? Yes No If yes: _____

Have you ever taken bisphosphonate medications for osteoporosis: Yes No If yes: _____

Current tobacco use? Yes No If yes: _____

Previous tobacco use? Yes No If yes: _____

Do you wear contact lenses? Yes No Do you wear removable dental appliances? Yes No

Allergies: Are you allergic to any of the following? Check all that apply:

◯ Aspirin	◯ Penicillin	◯ Codeine	◯ Acrylic
◯ Metal	◯ Latex	◯ Sulfa Drugs	◯ Local Anesthetic

Are you allergic to anything not listed above? Yes No If yes, please explain:

Do you have, or have you had, any of the following? Check all that apply.

High Blood Pressure	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Heart Attack	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Chest Pain / Angina	◯ Yes	◯ No
Congestive Heart Failure	◯ Yes	◯ No
Heart Valve Replacement	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No
Congenital Heart Defect	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
COPD	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No
Stomach / Intestinal Disease	◯ Yes	◯ No
Acid Reflux / GERD	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No
Low Blood Sugar	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No

Renal Dialysis	◯ Yes	◯ No
Parathyroid Disease	◯ Yes	◯ No
Recent Weight Loss	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Tumor or Growth	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Excessive Bleeding	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No
Alzheimer's / Dementia	◯ Yes	◯ No
Fainting Spells	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Shortness of Breath	◯ Yes	◯ No
Mental Health Problems	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No
Cold Sores / Fever Blister	◯ Yes	◯ No
Shingles	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Hepatitis	◯ Yes	◯ No
HIV / AIDS	◯ Yes	◯ No
STD	◯ Yes	◯ No
Sinus Problems	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Dry Mouth	◯ Yes	◯ No
Sore Jaw Muscles	◯ Yes	◯ No
Popping / Clicking in TMJ	◯ Yes	◯ No
Sleep Apnea	◯ Yes	◯ No

Women: Are you? ◯ Pregnant/Trying to pregnant ◯ Nursing ◯ Taking oral contraceptives

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

KING & MILES
FAMILY DENTISTRY

Joseph W. King, D.D.S. - Mary J. Miles, D.M.D.

General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects.
- Damage to adjacent teeth or fillings.
- Post-operative infection.
- Post-operative bleeding that might require additional treatment.
- Delayed healing of an extraction site, (dry socket) necessitating additional care.
- Sinus involvement during removal of upper teeth which may require additional treatment or surgical repair at a later date.
- Swallowing or aspiration (inhalation into the respiratory system) of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. resulting in the need for further medical treatment.
- Changes to the treatment plan due to the conditions discovered during treatment that were not evident at the time of examination. (For example, root canal therapy following routine restorative procedures resulting in the need for additional treatment)
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.
- Bruising, swelling, sensitivity or pain.
- Failure of the dental procedure necessitating additional treatment.
- Breakage of dental instruments inside tooth canals making additional treatment necessary.

I understand there may be associated risks for any recommended treatment, as well as the consequences of doing nothing. I understand that dentistry is not an exact science and therefore my dental practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurances have been made by anyone regarding dental treatment.

Date: _____

Patient Signature: _____

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FAMILY DENTISTRY

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Office Financial Policy

Thank you for choosing us as your dental provider. Our primary goal is to help you keep your teeth for a lifetime. Your comfort, appearance and long-term dental health needs will be kept in mind at all times. When treatment is indicated, we will try to restore optimum dental health in as few, well-planned appointments as necessary. We recognize the value of your time.

Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. Therefore, we need your assistance and understanding of our office financial policy as follows:

1. Payment is expected at the time of service, and may be made by cash, checks, credit card, post-dated check, or financing (see us for financing details and information on CareCredit). Credit checks may be performed at our discretion.
2. For multiple appointment treatment, **one-half** is payable the first appointment and **one-half** is payable the last appointment. If the entire fee is paid by cash or check on the first appointment, a 5% discount will be given.*
3. Senior citizens will be given a 10% discount.*
4. If an insurance company or other plan is assisting you in payment, the above discounts do NOT apply. ***Insurance laws prohibit us from offering discounts on co-pays and out-of-pocket expenses to our insured patients.**
5. Missed appointments may be charged a $25.00 fee at our discretion.
6. Insurance benefits are an estimated aid; therefore, estimated co-payments **will be collected on the day of service.**

   You must provide insurance information including **claim address and coverage details.** If you cannot provide the needed information on or before your appointment, you will be responsible for the full fee and must wait for your insurance company's reimbursement.

   Your insurance is a contract between you and the insurance company. We are NOT party to that contract; however, we are happy to file insurance claims on our patients' behalf. Not all services are a covered benefit. Insurance companies arbitrarily select the services they will not cover.

   Any account balance 60 days overdue will be billed at 1.5% interest per month.
7. Hoosier Accounts will be given any inactive account 90 days past due.
8. Returned checks are subject to bank charges and a $30.00 service charge.

If you have any questions or are uncertain about the information, **please** don't hesitate to ask us. **We are here to help!**

I understand and agree that regardless of my insurance, I am responsible for the balance of my account for any professional services rendered. I have read and understand all the information on this sheet.

NAME (Please Print)_____**DATE**_____

SIGNATURE_____**DATE**_____

PARENT/GUARDIAN_____**DATE**_____

NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("Notice") desribes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services. Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION - We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

HOW WE MAY USE AND DISCLOSE YOUR PHI :

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.
Payment – We may use and disclose your PHI to obtain payment for services provided to you.
Healthcare Operations – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.
Appointment Reminders – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.
Required by Law – We may use or disclose your PHI when required by federal, state, or local law.
Emergencies – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.
Public Health Activities – We may disclose PHI for public health purposes, including disease prevention and reporting.
Military, National Security, and Protective Services – We may disclose PHI as required for military activities, national security, and protective services.
Research – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.
Legal Proceedings – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.
Marketing – We will not use your PHI for marketing purposes without your written authorization.
Personal Representatives – We may only disclose your PHI to a personal representative authorized by you in writing.
Business Associates – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.
Workers' Compensation – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD). Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

How SUD Information May Be Used

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions. Prohibition on Legal Use SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order. Redisclosure Limitations -SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules. Fundraising Restrictions - Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/ location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the OCR without retaliation

CHANGES TO THIS NOTICE - We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

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FAMILY DENTISTRY

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Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices

Name (please print)_____

Signature_____

Date_____

Please mark below if you are over 18 years old and would like our office to be able to discuss your dental care with a family member or other designated individual. If not, leave this section blank.

○ I authorize King & Miles Family Dentistry to discuss my dental treatment, appointments, insurance information, account balance, payment arrangements, and other information related to my care with the following individual(s):

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

I understand that this authorization is voluntary and may be revoked by me at any time in writing, except to the extent action has already been taken in reliance on this authorization.

Signature_____

Date_____