Virginia H. Ellis, DDS
Dental Corp.
Family and Cosmetic Dentistry

Confidential Health History

Name:_____ DOB:_____ Today's Date:_____

Are there any areas in your mouth that you would like to improve/change?

Do you have any questions or concerns?

Caries (tooth decay):

Do you consider yourself cavity prone?.....Y N

Do you consume sugary foods regularly?.....Y N

Do you consume energy drinks or sports drinks?.....Y N
If yes, what type and how often?

Does your mouth feel dry?.....Y N

Do you have heartburn or acid reflux?.....Y N

Periodontal Disease:

Have you been told you have gingivitis or gum disease?.....Y N

Do your gums ever bleed when you brush or floss?.....Y N

Do you have gum recession or exposed root surfaces?.....Y N

Do you have any loose teeth or areas that collect food when you eat?.....Y N

Oral Medicine:

Do you take over the counter medicines?.....Y N

Do you have any persistent sores in your mouth or lumps/bumps on your head or neck?.....Y N

Do you feel as if you have a lump in your throat?.....Y N

Do you ever get cold sores?.....Y N

Medical Care:

Are you currently being treated for any medical conditions?.....Y N
If yes, please list:

Do you get annual medical check-ups?.....Y N

Do you see a dermatologist for an annual skin cancer screening?.....Y N

Function/Bite/TMJ:

Do you ever experience discomfort when chewing?....Y N

Do your jaw joints click, lock, pop or make grinding sounds?.....Y N

Do you experience frequent headaches or jaw/facial pain?.....Y N

Have you ever been told that you grind your teeth?...Y N

Have you been treated for a jaw joint problem?.....Y N

Do you wear a retainer or night guard?.....Y N

Cancer:

Do you have a cancer diagnosis or history?.....Y N

Are you undergoing cancer treatment?.....Y N

Pre-Diabetes and Diabetes

Have you ever been diagnosed with pre-diabetes or diabetes?.....Y N

If so, what type?.....I II

Do you take medication(s) for diabetes, hypertension or high cholesterol?.....Y N
Please list medications:

Medical Conditions:

Do you have or have had any of the following? Please circle:

Anaphylaxis	**Hearing disorder**
Anemia	**Hives/skin rash**
Anxiety	**Kidney problems**
Artificial joints	**Liver problems**
Blood disease	**Lung disease**
Blood transfusion	**Pacemaker**
Congenital heart defect	**Psychiatric problems**
Endocrine problems	**Seizures/Epilepsy**
Heart murmur	**Sinus problems**
Hepatitis A, B or C	**Thyroid disease**
Herpes	**Tuberculosis**
HIV/AIDS	**Tumor or growth of head/neck**

OTHER:

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Brain/Organ Health:

Have you been diagnosed with dementia, Alzheimer's or any other brain function ailment?.....Y N
If yes, please specify condition:

Are you aware of or being treated for any vital organ disease?.....Y N
If yes, please list:

Habits:

Do you smoke or chew tobacco?.....Y N
If so, how often/how much:

Do you use cocaine or other drugs?.....Y N

Do you consume alcohol?.....Y N

Are you in recovery or being treated for addiction?.....Y N

Allergies, Food Sensitivities:

Do you have asthma?.....Y N

Do you use an inhaler?.....Y N

Have you identified any food sensitivities such as dairy, wheat or soy?.....Y N

Do you ever have heartburn?.....Y N

Are you allergic to any of the following? Please circle:

Latex Aspirin Codeine Tetracycline Valium Metals Sulfa Drugs Novocaine/Local anesthetic Nitrous Oxide Penicillin/Antibiotics Erythromycin Vicodin Percodan

Other:

Exercise/Sleep:

Do you exercise regularly?.....Y N

Do you snore or have difficulty sleeping?.....Y N

Bone/Joint Health:

Have you had joint replacement surgery?.....Y N
If yes, please specify:

Have you taken antibiotics for dental appointments as a result of joint replacement?.....Y N

Have you been diagnosed with Osteopenia or Osteoporosis?.....Y N

Are you currently taking or have you taken bisphosphonate drugs (Such as; Fosamax, Boniva, Actonel, Zometa)?.....Y N

Do you have joint inflammation, pain, arthritis or rheumatism?.....Y N

Cardiovascular Health:

Are you currently being treated for high blood pressure or cardiovascular disease?.....Y N

Do you currently take blood pressure medicine?.....Y N

Have you had any heart valves replaced?.....Y N

Do you have a history of heart attack, stroke, bypass or stints?.....Y N

Have you ever taken Phen-Phen or Redux?.....Y N

Are you taking blood thinners?.....Y N
If so what kind:

Do you take baby aspirin?.....Y N

Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements:

Women Only:

Are you pregnant or could you be pregnant?.....Y N

Are you nursing?.....Y N

Are you taking birth control pills?.....Y N

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient Signature:_____ **Date:**_____

Dr. Signature:_____ **Date:**_____

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.
Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations Incidental

- Disclosures that are an unavoidable by-product of permitted uses or disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 7, 2013, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Virginia H. Ellis to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Patient/Guardian Signature:_____ **Date:**_____

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Patient Information

Circle One: Dr/Mr/Mrs/Ms/Miss I prefer to be called:_____

First:_____ Middle:_____ Last:_____

Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Please contact me via: **Text Cell Email Home Phone**

Patient Social Security Number:_____ Date of Birth:_____ Sex: **M F**

Emergency Contact/Relationship:_____ Phone:_____

How did you hear about us?

□Website □Postcard in Mail □Facebook □Saw our Office/Sign □Search Engine (Google, Yelp)

□Friend/Relative: □Other:

Insurance Information:

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	□Self □Spouse □Child □Other	Relationship to Subscriber	□Self □Spouse □Child □Other
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
PLEASE PRESENT YOUR INSURANCE CARD TO OUR OFFICE MANAGER TO BE PHOTOCOPIED			

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Virginia H. Ellis to act as my agent in helping me obtain payment from my insurance companies. I authorize payment to Virginia H. Ellis, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers and email addresses for the purpose of treatment, insurance, or payment.

Patient/Guardian Signature:_____ Date:_____

77 Moraga Way, Suite E Orinda, Ca
OrindaDentist.com
925.254.4043

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Office Policies

- **Receipt of Dental Materials Fact Sheet**

I, _____, acknowledge I have received from Virginia H. Ellis DDS, a copy of the Dental Material Fact Sheet.

- **Cell Phone Consent**

I consent to the dental practice using my cell phone number to (circle one or both) **Call or Text** regarding appointments, treatment, insurance and my account. I understand that I can withdraw my consent at any time.

Patient Cell Phone Number: _____

- **Consent for Treatment**

I hereby authorize the doctor and/or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood, and agree to the above treatment policy. *Initial*:_____

- **Financial Policies**

Cost of Treatment

You will be provided with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing.

Payment Policy

Payment in full is due at time treatment is provided. All major credit cards accepted. A 5% pre-payment courtesy is given when paying with cash or check up-front, in-full for treatment. We also offer third-party financing through Care Credit.

Refund Policy

Patient will be notified of any credit on account and will be refunded via original form of payment. Cash payments will be refunded by check.

- **Cancelation Policy**

Please give our office at least 48 hours notice to cancel/change any appointments.

Patient/Guardian Signature:_____**Date:**_____

77 Moraga Way, Suite E Orinda, Ca
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