Today's Date:_____

Drs. Harkins, Hancock & Johnston, DDS

Patient Health History

NAME: _____ DOB: _____/_____/_____

PREFERRED PHARMACY: _____

PRIMARY CARE PHYSICIAN/#: _____

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

- ☐ Asthma *if yes,* where do you keep your inhaler?
  _____
- ☐ Bleeding Problems
- ☐ Epilepsy/Seizures
- ☐ Prosthetic Heart Valve
- ☐ Artificial Joint List/Date: _____
- ☐ Hepatitis/Liver Disease
- ☐ Tuberculosis
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Cancer Type/Date: _____
- ☐ Chemo/Radiation Date: _____
- ☐ Shortness of Breath
- ☐ Breathing Problems/COPD
- ☐ Steroid Use
- ☐ Kidney Problems
- ☐ Psychiatric Therapy
- ☐ Any Addiction List: _____
- ☐ Vertigo
- ☐ Hypertension
- ☐ Hypotension
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Anemia
- ☐ Sexually Transmitted Disease
- ☐ Eating Disorders
- ☐ Hospital/Surgery *if yes,* what and when?
  _____
  _____
- ☐ Other condition or disease not listed
  _____

Do you take blood thinners (ex. Coumadin, Plavix, ect.)?_____

Please list names of medications, vitamins, and supplements you are taking.

Name of Medication	Condition for Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to or have you ever had an adverse reaction to:

- ☐ Local Anesthetics/ Novocain
- ☐ Latex
- ☐ Antibiotic _____
- ☐ Codeine
- ☐ Aspirin/Advil
- ☐ Any metals (ex. Nickel, Mercury ect.)
- ☐ Barbiturates, Sedatives or Sleeping Pills
- ☐ Sulfa Drugs
- ☐ Other _____

Temporomandibular Joint Symptoms

- ☐ Do you have any jaw pain or headaches?
- ☐ Are they frequent and/or severe?
- ☐ Does it hurt to open wide/yawn, chew?
- ☐ Do you take muscle relaxers or pain relievers?

What is your level of Anxiety/Stress/Fear when going to the dentist? (*Circle one*)

None ☐ Mild ☐ Moderate ☐ Severe ☐

Today's Date:_____

The following risk factors make it much easier for Periodontal (gum) Disease to develop:
Please list all the risk factors that you have:

- ☐ Current tobacco user: What kind? _____ How much/day? _____ How Long? _____
- ☐ Previous tobacco user: When did you quit? _____
- ☐ Family history of gum disease? (Parents lost teeth at an early age, or gum disease on your side of the family)
- ☐ Stress
- ☐ Previous bouts of gum disease/gingivitis
- ☐ Spouse with gum disease (Gum disease may be transmissible, all family members should be screened)
- ☐ Osteoporosis
- ☐ Taking Dilantin, CA+ Channel Blockers, or Immunosuppressant's for organ transplantation
- ☐ Diabetes

Heart Disease

Untreated gum disease can increase your risk for heart attack and stroke.

Have you been diagnosed with heart disease/stroke/heart attack?

- ☐ Yes
- ☐ No – Do you have any of these risk factors?
  - ☐ Family history of heart disease ☐ Tobacco use
  - ☐ High cholesterol ☐ High blood pressure

Who is your Cardiologist? _____

Diabetes

Diabetics are more prone to gum disease. Left untreated, gum disease makes it harder for diabetics to control their blood sugar. Diabetics who have their gum disease treated can improve their blood sugar control thus making diabetic complications less likely.

Are you a Diabetic?

- ☐ No Any family history of Diabetes? ☐ Yes ☐ No
  Do you have any of these warning signs of Diabetes?
  - ☐ Frequent urination ☐ Excessive thirst/hunger
  - ☐ Weakness/fatigue ☐ Slow healing of cuts
  - ☐ Unexpected weight loss
- ☐ Yes How is your Diabetes control? ☐ Good ☐ Fair ☐ Poor
  Date of last HbA1c_____ Score_____

Who is your Diabetes doctor? _____

Rheumatoid Arthritis

If you have Rheumatoid Arthritis, emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of Arthritis.

Have you ever been diagnosed with Rheumatoid Arthritis?

- ☐ Yes
- ☐ No

Alzheimer's Disease

Research suggests that patients with long standing gum disease may be more likely to develop adverse mental decline as they age.

Do you currently have Alzheimer's Disease or Dementia?

- ☐ Yes
- ☐ No

Do you have a family history of Alzheimer's Disease or Dementia?

- ☐ Yes
- ☐ No

Females:

Are you: ☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills

Are you post-menopausal? ☐ Yes ☐ No

Do you have Osteoporosis? ☐ Yes ☐ No Have you ever been tested for Osteoporosis? ☐ Yes ☐ No

Do you have any of the following <u>risk factors</u> for Osteoporosis? (*Check those that apply*)

- ☐ Post-menopausal ☐ Family history of Osteoporosis ☐ Early menopause
- ☐ Rheumatoid Arthritis ☐ Inadequate exercise ☐ Tobacco use/smoking

Have you ever taken *Fosamax, Fosamax Plus D, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors,* or *Zometa* for Osteoporosis or for any other reason? ☐ Yes ☐ No

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____
FIRST MI LAST

ADDRESS_____ CITY_____ STATE_____ ZIP_____

E-MAIL_____ SS#_____ BIRTHDATE_____ PHONE #_____

MOBILE PHONE #_____ CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED

IF COLLEGE STUDENT, F.T./P.T., NAME OF SCHOOL_____

PATIENT'S/PARENT'S EMPLOYER_____ WORK PHONE #_____

BUSINESS ADDRESS_____ CITY_____ STATE_____ ZIP_____

SPOUSE OR PARENT'S NAME_____ EMPLOYER_____ WORK PHONE #_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE #_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE #_____ DRIVER'S LICENSE #_____ D.O.B._____ SS#_____

EMPLOYER_____ WORK PHONE #_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

A Finance charge will be assessed on any outstanding balance using a periodic rate of 1.5% - annual percentage rate of 18% - The outstanding balance is that part of the balance remaining unpaid after payments and credit adjustments have been subtracted. Accounts sent to collections are liable for all costs. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ (X)_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUNT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____

Joe Harkins, DDS
Jeff K. Hancock, DDS
Blake A. Johnston, DDS
11010 Quaker Ave.
Lubbock, TX 79424
806-795-4272

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name:_____
Address:_____
Telephone:_____E-Mail:_____
Social Security #_____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Harkins & Hancock Dentistry_____
Telephone: 806-795-4272_____Fax: 806-791-2273_____
E-Mail: info@smilesofwesttexas.com_____
Address11010 Quaker Ave., Lubbock, TX 79424_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

DISCLOSURE TO OTHER NON-MEDICAL PERSONS

I authorize my dental information to be disclosed to the following persons:

NAME	ADDRESS	PHONE NO.	RELATIONSHIP

Signature:_____Date:_____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____