# HEALTH HISTORY UPDATE

Patient Name_____DOB_____Male □ Female □
Address_____
Home phone #_____ Work phone_____ Cell phone _____
SS#_____ Email Address _____
Dental Insurance Co_____ Phone #_____
Name of insured:_____ Group# _____
Insured SS#_____ Insured ID#_____ Insured DOB _____

***A change in your health status should be reported to the office at the earliest possible time.***

Currently under the care of a physician? Yes □ No □
If yes for what condition?_____
Are you taking any medication regularly? Yes □ No □
If yes, list medications and for what reason taken:
_____
_____
_____
_____

Do you have, or ever had an allergic reaction to:
Local Anesthetics Yes □ No □
Penicillin Yes □ No □
Sulfa Drugs Yes □ No □
Aspirin Yes □ No □
Codeine Yes □ No □
Latex Yes □ No □
Bandaid Only Yes □ No □
Any severe food allergies? Yes □ No □

Do you suffer from Dry-Mouth? Yes □ No □
Mild □ Moderate □ Severe □
Number of alcoholic drinks per week? _____

In the last 6 months, have you taken one of the following Biophosphonate Derivatives for the prevention of Osteoperosis: Fosamax, Actonel, Didronel, Boniva, Avedia, Skelid or Zometa? Cicle if any Yes □ No □

Blood thinners? If yes, name? _____ Yes □ No □
Circle if taken daily: Fish Oil, Aspirin or Ibuprofen
Yes □ No □
Circle if any heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular heartbeat
Circle if any abnormal blood pressure, excessive bleeding or anemia

History of heart issues:
Valvulitis Yes □ No □
Endocarditis Yes □ No □
Artificial heart valve Yes □ No □
Heart Valve Repair Yes □ No □
Congenital Heart Conditions Yes □ No □
Unrepaired Cyanotic CHD Yes □ No □
Heart/Organ Transplants Yes □ No □
Palliative Shunts & Conduits Yes □ No □

Have you been told to take antibiotics prior to dental treatment? Reason: _____Yes □ No □

Any prosthetic Joint replacement? Yes □ No □
Where and when was the surgery? _____
_____
Auto-immune disease? Name? _____Yes □ No □
Circle if any asthma, Tuberculosis or COPD
Mild □ Moderate □ Severe □
Circle if any Cancer, Tumors, Growths, Radiation Treatment or Chemotherapy
Are you currently being treated? Yes □ No □
Diabetic or have family history of diabetes? Yes □ No □
Who? _____
Circle if any Hepatitis, jaundice, or liver disease, kidney problems or renal dialysis
Circle if any: HIV, AIDS, Syphillis
Circle if any: Stroke, convulsions, fainting spells or epilepsy?
Rheumatoid arthritis? Yes □ No □
Tobacco use? Yes □ No □
If yes type & quantity: _____
Do you suffer with GERD? (*Acid Reflux*) Yes □ No □

Are there any other problems about your health of which you are aware? _____
_____

For women: Are you pregnant? Yes □ No □
Circle if you are taking any hormones, birth control

NOTE: To the best of my knowledge, the foregoing questions have been answered accurately.

_____
Signature Date

If other than patient, indicate relationship:_____

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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: _____

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*** if Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

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

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES 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: _____ Phone:_____

Name: _____ Relationship: _____ Phone: _____

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

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

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email 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.

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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

**Dale W. Greer, D.D.S.**
**5925 Forest Lane, Suite 311**
**Dallas, Texas 75230**

# HIPPA (Health Insurance Portability and Accountability Act)

## Our Privacy Pledge

**1. We want you to understand that we respect your privacy. We will not sell your health information or provide any of your health information to any outside marketing company. Dr. Greer or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider, if it is necessary for diagnosis, assessment, or treatment of your health/dental condition.**

**2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party (3rd party) , such as an insurance carrier, your employer, a family member, other relative or close personal friend, adjustor or attorney who is involved in our care or to facilitate the payment related to your care.**

**3. Dr. Greer and staff may need to use your information (ex. name, address, phone number, e-mail and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. I authorize the use of my information to Dr. Greer and staff for communication purposes.**

***Please initial items below:***

_____ **AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my treatment to any (3rd party) insurance company, adjuster, health care provider, attorney, clinical and dental laboratories, pharmacies or referring dentists involved in my case.**

**I acknowledge I have read the Health Insurance Portability and Accountability Act Privacy Form provided by Dr. Dale Greer and have received a copy if I requested.**

_____ **APPOINTMENTS: When you schedule an appointment with our office, we reserve that time specifically for you. We require at least 24 hours cancellation notice, as we have a long waiting list for appointments. If we do not receive 24 hours cancellation notice, this will be considered a "No Show" appointment. You will be billed a charge of $75.00 or greater for the time you reserved in our office.**

_____ **FINANCIAL RESPONSIBILITY: I understand I am personally responsible for any treatment balance incurred for myself and/or my family with Dr. Dale Greer. *We are pleased to assist you with your Dental Insurance, however Dr. Greer is not contracted with any insurance company*. I understand I am responsible for any balance not paid or covered by my insurance and if the insurance pays me personally, I am responsible for any balance due to Dr. Greer.**

_____ **PHOTO/IMAGES RELEASE: I consent to allow use of any before and after photos or images taken of my treatment case to be used for educational purposes. *Please circle* YES or NO.**

**I have reviewed and give my consent/approval to the above Practice Policies and Privacy Policy (HIPPA) for the office of Dr. Dale W. Greer. Thank you for your cooperation!**

**Signature**_____**Date**_____