The Art of Dentistry

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MEDICAL HISTORY UPDATE FORM

DATE _____ PATIENT NAME _____ BIRTHDATE _____

ADDRESS _____City/State/Zip_____ E:MAIL _____

HOME PHONE _____ BUS PHONE _____ CELL PHONE _____

YOUR PHYSICIAN'S NAME _____ LAST VISIT DATE _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES / NO IF YES, NATURE OF CARE: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO __ IF YES, WHAT? _____

ANY RECENT SERIOUS ILLNESS? _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? _ YES __ NO

IFYES, REASON: _____ _

PLEASE LIST ALL THE NAMES AND PHONE NUMBERS OF THE PHYSICIANS WHO ARE CURRENTLY PROVIDING YOU CARE:

_____

Abnormal bleeding from a cut	Yes	No	High Blood Pressure	Yes	No
AIDS (HIV+)	Yes	No	Joint Replacement	Yes	No
Allergy to Anesthetic	Yes	No	Kidney or Liver Disease	Yes	No
Anemia	Yes	No	Latex Sensitivity	Yes	No
Arthritis	Yes	No	Other Infections	Yes	No
Artificial Joints	Yes	No	Previous Biopsies	Yes	No
Asthma	Yes	No	Prolonged Bleeding	Yes	No
Bruise Easily	Yes	No	Psychosis	Yes	No
Cancer	Yes	No	Recurrent Illnesses	Yes	No
Chemotherapy or Radiation Illnesses	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Sinus Trouble	Yes	No
Emotional Stress	Yes	No	Slow- Healing Mouth Sores	Yes	No
Emphysema or other Respiratory Illnesses	Yes	No	Sore/Enlarged Lymph Nodes	Yes	No
Epilepsy	Yes	No	Substance Abuse	Yes	No
Glaucoma	Yes	No	Sulfa Allergy	Yes	No
Heart Attack	Yes	No	Thyroid Disease	Yes	No
Heart Disease	Yes	No	Ulcers	Yes	No
Heart Murmur (Mitral Valve Prolapse)	Yes	No	Unintentional Weight Loss/ Gain	Yes	No
Heart Valve Replacement	Yes	No	Venereal Disease	Yes	No
Hepatitis, Any Form	Yes	No	Other Concerns	Yes	No
Herpes Infection	Yes	No	Past treatment for Osteoporosis, Osteopenia, or Paget's Disease	Yes	No

ARE YOU A SMOKER? ……YES__ NO__

IF SO, HOW MUCH DO YOU SMOKE PER DAY?_____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? YES __ NO __

IFYES, PLEASE EXPLAIN: _____

ARE YOU REQUIRED TO PRE-MEDICATE BEFORE DENTAL TREATMENT? ..... YES __ NO__

WOMEN: ARE YOU PREGNANT? ..... YES__ NO__

IF NO, ARE YOU PLANNING A PREGNANCY IN THE NEAR FUTURE? ..... YES__ NO__

ARE YOU A NURSING MOTHER? ..... YES__ NO__

ARE YOU TAKING BIRTH CONTROL PILLS? ..... YES__ NO__

ABNORMAL BLOOD PRESSURE? ..... YES__ NO__

IF YES, WHAT IS IT USUALLY: S /D

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

A.LOCAL ANESTHETICS ..... YES__ NO__

B.PENICILLIN OR OTHER ANTIBIOTICS ..... YES__ NO__

C.ASPIRIN ..... YES__ NO__

D.CODEINE, VALIUM OR OTHER SEDATIVES ..... YES__ NO__

E.OTHER, _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

1. _____ 2._____

3. _____ 4._____

5. _____ 6._____

ARE YOU TAKING ANY HERBAL SUPPLEMENTS/MEDICINES? .....YES__ NO__

IF YES, PLEASE LIST_____

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 changes in my health and medication.

The undersigned hereby authorizes Dr. Lyford and staff to take radiographs, study models, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Lyford to perform any and all forms of treatment, medication, and therapy which may be indicated in connection with the patient, and further authorize and consent that Dr. Lyford choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies certain inherent risks, which may include but are not limited to temporary paresthesia, self-induced trauma, and allergic reactions.

I understand that responsibility for payment for services provided in this office for myself or my dependents is mine, *due and payable at the time services* are rendered. For your convenience we offer the following methods of payment in full at each appointment: Cash - Personal Check - Visa - MC - Amex - Discover

I understand that my insurance is an agreement between my dental insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If your account is sent to a collection agency, you will be responsible for any and all costs involved in the collections process. This will include all court costs, attorney fees, and correspondences. There will be a charge of $50.00 for all returned checks. Our office requires 48 hour notice for any canceled appointments to *avoid* a $125.00 cancellation fee.
I understand the consent and will proceed with treatment as long as I agree with Dr. Lyford's recommendations.

_____ _____ _____

Print Name Patient Signature Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Arthur O. Lyford, DMD, PLLC to share information regarding all my dental treatment to the person(s) listed below:

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

This authorization is in effect until I notify Dr. Lyford in writing.

I understand that if I cancel my authorization, I will still be able to receive any treatment, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive. Shared information may include all or part of my dental history, dental treatment plan, and financial plan. I realize that some or all aspects of my medical health and medical history may be revealed and/or discussed as it is necessary to consider this aspect of my health in relation to my dental needs.

- I authorize the use or disclosure of my individually identifiable health information as described above.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the dental information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

ARTHUR O. LYFORD, D.M.D., P.L.L.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. ☞ THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may also request access by sending us a letter to the address at the end of this Notice. We reserve the right to charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.