



## HISTORY

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

What health concerns and symptoms bring you to the clinic? (List in order of severity)

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Additional concerns: \_\_\_\_\_

**ALLERGIES** (Please list the response next to each allergy - i.e. rash, hives, anaphylaxis)

**Medication Allergies:**  Aspirin \_\_\_\_\_  Penicillin \_\_\_\_\_  Codeine \_\_\_\_\_  
 Local \_\_\_\_\_  
Anesthetics \_\_\_\_\_  Sulfa drugs \_\_\_\_\_  Others: \_\_\_\_\_

**Environnemental/Food Allergies:**  LATEX \_\_\_\_\_  Acrylic \_\_\_\_\_  Metal \_\_\_\_\_  
 Others: \_\_\_\_\_

**WOMEN** – Are you pregnant?  yes  no Trying to become pregnant?  yes  no  
Are you breast-feeding?  yes  no Are you taking oral contraceptives?  yes  no

### Past Medical History

Please check any medical conditions or health problems that you now have or have had in the past and circle those that are currently under the care of a physician or health care professional:

Headaches (Migraines, other)	<input type="checkbox"/> now <input type="checkbox"/> past	Heart Disease	<input type="checkbox"/> now <input type="checkbox"/> past
Seizure Disorders	<input type="checkbox"/> now <input type="checkbox"/> past	Chest Pain	<input type="checkbox"/> now <input type="checkbox"/> past
Recurrent sinus infections	<input type="checkbox"/> now <input type="checkbox"/> past	Irregular Heart Beat	<input type="checkbox"/> now <input type="checkbox"/> past
Seasonal allergies	<input type="checkbox"/> now <input type="checkbox"/> past	High Blood Pressure	<input type="checkbox"/> now <input type="checkbox"/> past
Psychiatric or Emotional	<input type="checkbox"/> now <input type="checkbox"/> past	Blood Clotting	<input type="checkbox"/> now <input type="checkbox"/> past
Depression	<input type="checkbox"/> now <input type="checkbox"/> past	Bleeding disorder	<input type="checkbox"/> now <input type="checkbox"/> past
Anxiety or excessive stress	<input type="checkbox"/> now <input type="checkbox"/> past	Stroke/vascular	<input type="checkbox"/> now <input type="checkbox"/> past
Asthma	<input type="checkbox"/> now <input type="checkbox"/> past	Diarrhea	<input type="checkbox"/> now <input type="checkbox"/> past
Chronic bronchitis	<input type="checkbox"/> now <input type="checkbox"/> past	Liver disease	<input type="checkbox"/> now <input type="checkbox"/> past
Lung or breathing problems	<input type="checkbox"/> now <input type="checkbox"/> past	Kidney disease	<input type="checkbox"/> now <input type="checkbox"/> past
Chronic Indigestion	<input type="checkbox"/> now <input type="checkbox"/> past	Menstrual disorders	<input type="checkbox"/> now <input type="checkbox"/> past
Stomach Ulcers	<input type="checkbox"/> now <input type="checkbox"/> past	Reproductive	<input type="checkbox"/> now <input type="checkbox"/> past
Intestinal Disease	<input type="checkbox"/> now <input type="checkbox"/> past	Prostate problems	<input type="checkbox"/> now <input type="checkbox"/> past
Skin problems/dermatitis	<input type="checkbox"/> now <input type="checkbox"/> past	Sexual/Libido	<input type="checkbox"/> now <input type="checkbox"/> past
Back Pain or Sciatica	<input type="checkbox"/> now <input type="checkbox"/> past	Tendonitis	<input type="checkbox"/> now <input type="checkbox"/> past
Herniated Disc	<input type="checkbox"/> now <input type="checkbox"/> past	Chronic pain	<input type="checkbox"/> now <input type="checkbox"/> past
Neck pain	<input type="checkbox"/> now <input type="checkbox"/> past	Shoulder problems	<input type="checkbox"/> now <input type="checkbox"/> past
Chronic Muscle or Joint Pain	<input type="checkbox"/> now <input type="checkbox"/> past	Osteoarthritis	<input type="checkbox"/> now <input type="checkbox"/> past
Carpal Tunnel Syndrome	<input type="checkbox"/> now <input type="checkbox"/> past	Rheumatoid Arthritis	<input type="checkbox"/> now <input type="checkbox"/> past
Fibromyalgia	<input type="checkbox"/> now <input type="checkbox"/> past	Artificial joint/implants	<input type="checkbox"/> now <input type="checkbox"/> past
Diabetes	<input type="checkbox"/> now <input type="checkbox"/> past	Psoriasis or eczema	<input type="checkbox"/> now <input type="checkbox"/> past
Thyroid disease	<input type="checkbox"/> now <input type="checkbox"/> past	GERD	<input type="checkbox"/> now <input type="checkbox"/> past
Osteoporosis/Osteopenia	<input type="checkbox"/> now <input type="checkbox"/> past	Constipation	<input type="checkbox"/> now <input type="checkbox"/> past
Urinary troubles	<input type="checkbox"/> now <input type="checkbox"/> past	Difficulty Sleeping	<input type="checkbox"/> now <input type="checkbox"/> past
Sleep Apnea	<input type="checkbox"/> now <input type="checkbox"/> past		

AIDS/HIV positive                     now    past                    Blood Transfusion                     now    past  
 Drug Addiction                         now    past                    Sickle Cell Disease                     now    past  
 Hepatitis A                                 now    past                    Hepatitis B or C                         now    past

**List any additional health problems (Surgeries) not listed above:**

\_\_\_\_\_

**List any medications you are currently taking (or have taken in the recent past)**

Medication Name	Date Started	Date Stopped	Dosage (amt/# daily)
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
<b>5</b>			
<b>6</b>			
<b>7</b>			
<b>8</b>			
<b>9</b>			
<b>10</b>			

**(If any additional medications please attached a separate page)**

**Nutritional supplements, vitamins, herbs, homeopathic remedies taken:**    None  
 Multi-Vitamins    Trace Minerals    EPA-DHA (Omega-3's)    Macro- Minerals  
 (Calcium, Zinc, Magnesium)    Probiotics    Digestive Enzymes    Amino-Acids  
 Co-Enzyme Q-10    Antioxidants    Super Foods    Others: \_\_\_\_\_

**Family History** *(Write the relationship of the relative(s) with the disease on the adjacent lines)*

Heart Disease                             yes    no                    \_\_\_\_\_  
 High Blood Pressure                     yes    no                    \_\_\_\_\_  
 Diabetes                                     yes    no                    \_\_\_\_\_  
 Arthritis                                     yes    no                    \_\_\_\_\_  
 Skin disorders                             yes    no                    \_\_\_\_\_  
 Breast Cancer                             yes    no                    \_\_\_\_\_  
 Uterine/Ovarian Cancer                 yes    no                    \_\_\_\_\_  
 Prostate Cancer                            yes    no                    \_\_\_\_\_  
 Colon Cancer                               yes    no                    \_\_\_\_\_  
 Other Cancer                               yes    no                    \_\_\_\_\_

List any other disease/conditions in the family: \_\_\_\_\_

\_\_\_\_\_

**Social History and Personal Health Habits**

**General** (Check all that apply)

My health is  excellent  good  fair  poor.

My physical fitness is  excellent  good  fair  poor

I am under a lot of stress  I am fatigued all the time

I am having difficulty dealing with stress

I practice prayer, meditation, or other relaxation techniques  I am often sad and blue

I was breast fed as an infant  I was formula fed as an infant

I was given antibiotics under the age of 2 years

**Dietary Habits**

No special diet habits  I eat a healthy diet  Avoid red meat  Vegetarian

Minimizes fat  Minimizes carbs  Emphasizes grains

Emphasizes fruits and vegetables  Avoids processed dairy and cheese

I commonly consume:  Coffee  Regular soda drinks  Diet soda  Candy-chocolate

Chips - crackers  Fast food

**Exercise Habits**

No special exercise habits  I routinely exercise \_\_\_hr(s) \_\_\_X/week

Aerobic exercise (jog/walk/treadmill)  Lift weights  Swim

Stretch/Yoga/Tai Chi/Chi Gong Other \_\_\_\_\_

**Tobacco Use**

I never smoked cigarettes or chewed *tobacco*

I now smoke \_\_\_\_\_ packs of cigarettes per day. I have smoked for \_\_\_\_\_ years

I quit smoking in \_\_\_\_\_(mo/yr). I smoked \_\_\_\_\_packs/day for \_\_\_\_\_ years

**Alcohol Use**

I never drink alcohol  I drink occasionally or socially

I regularly drink: \_\_\_\_\_ drinks per day or \_\_\_\_\_ per week

**Hobbies/Sports/Recreation**

List routine hobbies/sports/recreational activities: \_\_\_\_\_

Preventive Tests:	Month/Year of last test	Test Results
Cholesterol/triglycerides	_____	_____
GI series (stool analysis) Stress EKG	_____	_____
Bone density ( <i>DEXASCAN</i> )	_____	_____
Colonoscopy	_____	_____
Gall bladder or kidney	_____	_____
Exercise stress test	_____	_____

Ultra sound tests

CBC Blood tests \_\_\_\_\_

Chemistry panel \_\_\_\_\_

Other Tests \_\_\_\_\_

Tetanus  Influenza  Smallpox  Pneumonia  Measles  Pertussis  Diphtheria

Mumps  Polio  Hepatitis B Other: \_\_\_\_\_

**WOMEN ONLY**

Are you currently taking or have you in the past taken hormones or oral contraceptives  yes  no

If yes, please list all hormones and oral contraceptives you have taken and when \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check any medical conditions or health problems that you now have or have had in the past:**

Breast Cancer  now  past

STD's  now  past

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEN ONLY**

Date of last Prostate Exam \_\_\_\_\_

Are you concerned with loss of muscle mass, tone, or strength?  yes  no

Has your abdominal girth and weight been increasing?  yes  no

STD's  yes  no

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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***Financial and Insurance Agreement***

I hereby agree to accept full financial responsibility for any dental work provided to \_\_\_\_\_ (Print Patient's name)

I understand that as a courtesy to me, there will be a treatment plan printed out, that is an "***estimate only***", based on standard insurance fee schedules and coverage. It is not the clinic's responsibility to know in detail each individual's specific insurance policy. "***Our staff will do its absolute best to provide you with the most accurate estimate***", but I understand that I will be responsible for interpreting my own insurance policy, benefits, and coverage. Any remaining balance after insurance coverage is expected to be paid in full on the day of service. Any balance remaining on the account after ninety days will be turned over for collections. Also, as a courtesy to you, personal checks will be accepted. However, we will forward the amount that the bank will charge us to the patient's account on any check that does not clear the bank. A money order, certified check, cash, or credit/debit card payment will be expected if a personal check does not clear.

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection fees.

**Authorization** I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me. I hereby authorize and acknowledge that any scanned signature is to be considered an original signature.

**Acknowledgement of Receipt of Privacy Practices Notice**

I hereby acknowledge that I have received a Notice of Privacy Practices from the practice as listed above.

***Upon signing this statement, I have thoroughly read the above policy and will be in compliance.***

Name (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## OUT-OF-NETWORK CONSENT FORM

Centre for Holistic and Biological Dentistry

[hbdentistry@toothemail.com](mailto:hbdentistry@toothemail.com)

615.481.4555 615.472.8925 fax

I, \_\_\_\_\_,  
(Print Full Name)

a member of \_\_\_\_\_,  
(Print Insurance Company)

have been informed by \_\_\_\_\_,  
(Print Name of Dentist, and/or Financial Manager)

The *Centre for Holistic and Biological Dentistry*, located at 1600 Westgate Circle, Brentwood, TN 37027 is an out-of-network, non-participating facility. Therefore, I understand that if I receive services at this facility, my out-of-network benefits will apply. In such case, I may have additional out-of-pocket expenses not covered by my insurance company for which I will be personally responsible. I also understand that in some instances, my insurance may not cover any benefits at all.

**For example:** If a service is performed at a participating business and incurs a charge of \$2,000, your insurance company may have a payment allowance of \$922 for the service. Your benefits will pay the \$922 allowance less any applicable deductible, and balance bill you for the difference.

A participating in-network provider cannot **balance bill** you the difference between what they have allowed and their actual charges. However, when using an out-of-network provider, you are personally responsible for the difference between the charges and the allowance paid by your insurance provider, which in *this example* would be \$1,078.

I acknowledge by signing this Consent Form that I have been informed by the Billing and Insurance manager, of alternative participating facilities within my participating network. However, I have chosen to receive services at the above out-of-network facility and accept responsibility for the additional costs that may be incurred.

***I understand this facility is not a participating network of my insurance provider and that I will be financially responsible for any additional out-of-pocket costs that may result. I further acknowledge that it is my responsibility to verify my out-of-network benefits with my insurance company and will not hold The Centre for Holistic and Biological Dentistry liable for any obscure or omitted contractual language in my insurance contract.***

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Patient or Responsible Party Signature

Date

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Staff member witness

Date



## Patient Policies

Due to the growing nature of our practice, we are making some policy changes to better serve all of our patients. We sincerely appreciate your continued support of our office.

**\*Please allow up to one (1) business day** for an assistant to return messages regarding dental questions.

**\*To respect other patients' time**, we ask that you only be seen for the dental issues for which you were scheduled. Any other dental problems outside of the scope of your appointment will need to be addressed in a separate appointment.

**\*If you arrive more than 15 minutes late** for your appointment, you may be asked to reschedule.

**\*We require a 24 hour confirmation on all appointments.** Any appointments that are not confirmed will be removed from our schedule.

**\*We require 48-hour notice for cancellation** of a scheduled appointment. Please call the office to reschedule or remove your appointment. If you are considered a "no show" for three (3) missed appointments or have excessive cancellations, we retain the right to dismiss you from our practice.

**\*It is your responsibility** to contact your insurance company prior to the appointment to verify coverage of your visit.

**\*Copays and past due balances** are due at the time of service.

***I hereby acknowledge I have read the policies listed above, and I understand my responsibilities as a patient of The Centre for Holistic and Biological Dentistry***

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Patient's Printed Name

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Patient's Signature

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Date



**Centre for Holistic and Biological Dentistry**

1600 Westgate Circle, Suite 175

Brentwood, TN 37027

hbdentistry@toothemail.com

615.481.4555 615.472.8925 fax

**HIPAA PRIVACY DISCLOSURE**

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date in which you last received services from us.

**CONSENT TO TREAT:** I voluntarily authorize The Centre for Holistic and Biological Dentistry as assistants or associates to administer examinations and care as deemed necessary for my condition.

Emergency Contact Name\_\_\_\_\_

Contact Phone\_\_\_\_\_

**AUTHORIZATION TO RELEASE RECORDS:** I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Print Patient Name\_\_\_\_\_

Patient Signature\_\_\_\_\_

Date\_\_\_\_\_

Witness Signature\_\_\_\_\_

Position\_\_\_\_\_

Date\_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

Please read *Notice of Privacy Practices* below. **\*\*Submitting this completed form with patients' samples constitutes acknowledgement and agreement of our Privacy Practices, the use of practitioner and patient contact information for customer service purposes, and the use of test data for research purposes.\*\***

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on May 7, 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

### 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 read and sign the acknowledgement of privacy practices.

#### Typical Uses and Disclosures of Health Information

We are committed to maintaining the privacy of your health information. This notice lists some of the reasons and examples why we might use or disclose your health information. Not every use or disclosure is covered, but all of the ways we are allowed to use and disclose information will fall into one of the categories.

**Treatment:** We may use and disclose medical information about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and *related* services with other health care professionals. We have established a "minimum necessary or need to know" standard that limits various staff members' access to your health information according to their primary job functions.

**Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from your insurance company or a third party payer.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. Medical information about you may be used to determine whether certain treatments are effective, additional services should be offered, services should be discontinued, or to notify you of additional services offered that might benefit your health or be of interest to you, such as research studies conducted by Quicksilver Scientific.

**Persons involved in your care:** We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. However, we may require you to give written permission. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances (prohibited by state law). You may ask us not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies). If the patient is a minor we may or may not be able to agree to your request.

**Emergencies:** We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care in case of any emergency involving your care, your location, and your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or *administrative* orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Your Privacy Rights As Our Patient Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Our lab personnel can provide you a copy of the form, the cost for the appointment and fees for each copied page. If you want the copies mailed to you, postage will also be charged. Once approved, an appointment can be made to review your records. Applicable fees will be collected prior to releasing the records.