Health History Information for Services

Patient Name: ___________________________________ Date of Birth: _______________________________

Today's Date: ___________________________ Phone Number: _____________________________________

Last Dental Visit: ___________________________ Dental Provider: _____________________________________

Chief Dental Concern Today: ____

Emergency Contact: ________________________________ Phone #: ________________________ Relation: __________

Primary Medical Provider: _________________________________ Last Medical Visit: ______________________________

Have you ever been diagnosed with, or treated for any of the following? (Check all that apply):

□Abnormal Bleeding	□Congenital Heart Defects	□Heart Disease	□Mitral Valve Prolapse
□Acid Reflux	□Congestive Heart Failure	□Heart Murmur	□Non- Epileptic Seizures
□ADHD	□COPD	□Hemophilia	□Obesity
□Alcohol Abuse	□Coronary Artery Disease(CAD)	□Hepatitis A	□Osteoporosis
□Anemia	□Diabetes Type I	□Hepatitis B	□Psychiatric Problems
□Anxiety	□Diabetes Type II	□Hepatitis C	□PTSD
□Artificial Bones/ Joints	□Drug Abuse	□HIV/ AIDS	□Rheumatic Fever
□Artificial Heart Valves	□Emphysema	□Hyperlipidemia (High Cholesterol)	□Rheumatoid Arthritis
□Asthma	□Epilepsy	□Hypertension (High Blood Pressure)	□Scarlet Fever
□Autism- mild	□Fainting Spells	□Joint Replacement; Type: ____________	
□Autism- severe	□Gestational Diabetes	□Kidney Disease	□Shortness of Breath
□Behavioral Issues	□Glaucoma	□Lupus	□Thyroid Disorder
□Blood Disorders	□Halitosis (Bad Breath)	□Migraines	□Tuberculosis
□Cancer	□Heart Attack	□Mouth Ulcers, Fever Blisters	
Receiving Treatment? Yes or No	□Other: ____		

□ Currently Pregnant, Due Date: ___________________ □ Currently Nursing

Are you currently taking any medications? (List any medications that you are currently taking):

____

____ □ No Current Medications

Please list all allergies:

____

____ □ No known Allergies

Please list any surgeries or hospitalizations:

____

____ □ No Surgeries or Hospitalizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strict confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize HHM Health Dental staff to perform the necessary dental services I may need.
Occasionally, photos and/or study models of HHM patients may be used for quality reporting. No names will be attached to any study models or photos used. I authorize HHM Health to use my photos and/or study models for this purpose.

Signature: ____ **Date:** __________________________

Dental Consent Form

Patient Name: ____ DOB: ____________________________

General Information: Patients accepted by HHM Health Dental will have their treatment.

Emergency Dental Care: Patients accepted by HHM Health Dental will have their treatment.

Consent to Dental Procedures: As a patient you will as all times have access to current and complete information about your condition will, unless otherwise specified, receive continuity or treatment, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. Before receiving treatment, you should ask the dentist or dental hygienist about the procedure(s) to be done. All dental procedures may involve the risk of unsuccessful results and complications, and no guarantee is made as to result or cure. You always have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risk of no treatment. **HHM Health hosts various training programs, and dental procedures may be rendered by fellows or resident providers under the direct supervision of a licensed dental provider.** You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-Rays: Dental radiographs will be made necessary and appropriate for examinations, diagnosis, consultation, and treatment.

Financial Responsibility: You will be charged for treatment according to the fee schedule in effect. A fee estimate will be provided prior to beginning treatment and generally you must be prepared to pay for services as they are performed. Fees are collected in full before the start of a procedure unless other arrangements are made in writing.

Dental Insurance: If you participate in a dental insurance network, HHM Health will file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you not have dental insurance coverage you can apply for our sliding fee discount program, please ask the front desk for our sliding fee program application. You must complete the application and provide proof of income to be certified for the sliding fee discount prior to any appointment.

Dental Medical Records: Dental medical records, radiographs, photographs, videos, models, and other diagnostic aids relating to your treatment are the property of HHM Health. You have the right to inspect such materials and to request a copy of your dental medical records and radiographs. There is at least a $25 fee for copying these items. You may also request to have your dental radiographs sent to another health care provider by signing a release of information form. In addition, your dental medical records may be used for instructional purposes and if it is, your identity will not be disclosed to individuals not involved in your care and treatment.

Keeping your appointments: You are required to be on time for your appointments. If you find you are unable to keep an appointment, you agree to notify the Dental clinic at least 24 hours in advance. A total of two cancellations without 24-hour notice, two missed appointments, or repeated unsuccessful attempts at arranging an appointment may be cause to discontinue your further treatment at HHM Health Dental.

Your signature on this form certifies that you have read and understand the information provided on this form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

Signature: ____ Date: _________________________

Witness Signature: ____