Welcome

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: Mailing address

City: State: Zip:

Occupation:

Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship:

Home Phone: ( ) *Include area codes*

Cell Phone: ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3-week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?			
Date of last physical exam:			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date treatment began? _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Allergies — Are you allergic to or have you had a reaction to: *To all **yes** responses, specify type of reaction.*	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay Fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐

	Yes	No	DK
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐

	Yes	No	DK
Chronic pain	☐	☐	☐
Diabetic Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, Specify: _____			

	Yes	No	DK
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: _____ Phone _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Hillcrest Dental Care, Inc
PATIENT REGISTRATION SHEET

12/2012

(Please Print)

Patient Information

Name: _____
Last First Middle Initial

Date of Birth:_____ **Male**_____ **Female**_____ **Marital Status** _____

Race: ___White/Caucasian ___Black/African American ___Hispanic/Latino ___Native American or Alaska Native

___Asian ___Multi-Racial ___Other_____ ___Unknown

Ethnicity: ___European American ___Hispanic/Latino ___Middle Eastern ___Multi-Ethnic ___Other_____ ___UnKnown

Annual Household Income: ___ $0 - 19,999 ___$20,000 - $39,999 ___ $40,000 - $59,999 ___$ 60,000 or more

Disability: ___Mental ___Physical ___None

Referred By:

___ Patient ___Advertisement ___Dentist ___Insurance Co ___Doctor ___Phonebook

___Hillcrest Employee ___Walk In ___Internet ___Other_____

Responsible Party

Parent/Guardian/Guarantor _____ Relationship _____

Mailing Address _____
Street/PO Box City/Town State Zip Code

Physical Address _____
Street/PO Box City/Town State Zip Code

Home Phone _____ Alternate Contact Number _____

Employer _____ Work Phone _____

Dental Insurance Information

Insurance Company _____ ID/Certificate # _____

Mailing Address _____
Street/PO Box City/Town State Zip Code

Group # _____ Effective Date _____ ID#_____

Policy Holder _____ Relationship to Patient _____

Date of Birth _____ Phone Number _____ SS # _____

Name of Employer _____ Work Phone _____

Address of Employer _____
Street/PO Box City/Town State Zip Code

I hereby authorize Hillcrest Dental Care to provide my dental treatment and to furnish information to my insurance carrier concerning diagnosis and treatment. Permission is given for release of my medical information to authorized individuals pertaining to continuity of care. **I understand that I am financially responsible for any or all of my bill that is not completely paid for by my insurance carrier.**

_____
Signature (Patient/Guardian/Guarantor) Relationship Date

Hillcrest Dental Care
PO Box 4699
788 South Street
Pittsfield, MA 01201-4699

Notice of Privacy Practices

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date

_____ _____
Witness Date

Assignment of Benefits

I hereby direct my insurance carrier to make all payments directly to Hillcrest Dental Care. I also acknowledge that I have read and understand Hillcrest Dental Care's Financial and Cancellation Policies.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date

_____ _____
Witness Date

Hillcrest Dental Care

Patient Name : _____ Date of Birth: _____

In order to assist us in keeping your information private please list any family, friends or caregivers that you would like to be involved in your care. By listing someone on this form you are authorizing Hillcrest Dental Care employees to discuss your treatment with them.

Name	Relationship	Date of Birth (for verification only)	Phone Number

Patient/Guardian Signature: _____

Date: _____

This information remains in effect unless terminated in writing by the patient/guardian.

788 South St. • Pittsfield, MA • tel: 413.445.6680 • fax: 413.443.3680

Hillcrest Dental Care

788 South Street Pittsfield, MA

Confirmation Policy

As a courtesy, calls are made to patients to confirm their upcoming appointment; it is ultimately the patients responsibility to confirm their appointment. A confirmation call is required to hold all appointments and calls must be received at least 24 hours in advance. ***Appointment slots will not be held for unconfirmed patients.*** If an unconfirmed patient arrives for the appointment they may be asked to wait or rescheduled to another date or time.

Cancellation Policy

Patients are requested to notify our office 24 hours in advance of a cancellation.

If a patient does not show up or cancels with short notice (short notice is defined as less than 24 hours) for their first appointment they will be immediately dismissed from our practice.

Patients that miss or cancel with short notice two (2) appointments within a six-month period will be dismissed from our practice.

This policy is in effect to best utilize our professional staff while servicing patients with their dental care needs.

If an appointment was missed due to uncontrollable circumstances, a letter may be written explaining the situation and asking for consideration of reinstatement of patient status.

Dental Operations Director
788 South Street
Pittsfield, MA 01201

Financial Policy

Payment in full for uninsured services is required at time of service.

Payment options include the following:

1) **Cash or Personal Check**- If a check is returned from the bank, this will result in the cancellation of any future appointments as well as a returned check fee of $30.00 on your account. Future appointments can be scheduled once balance is paid in full.

2) **Visa/Master Card or Care Credit**- Applications for Care Credit can be obtained from the receptionist.

3) **Dental Insurance**- We will submit only to your primary dental insurance, it is up to the subscriber to submit to any secondary insurance. Any portion that is not covered is your responsibility and will be due at time of service.

Hillcrest Dental Care

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 4/14/2003 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 official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, e-mail 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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient's Bill of Rights

Your Rights as a Patient

We at Hillcrest Dental Care, Inc. support the rights of our patients. Because we want you to know your rights as a patient, here is a condensed version of the federal law and Massachusetts Patients' Bill of Rights. We encourage you to take an active role in your plan of care, including understanding your treatment and care. **If you have any questions, please contact the HDC, Inc. at 413.445.6680**.

Patient Rights

- You have the right to obtain the name and specialty of the doctor or other person responsible for your care.
- You have a right to confidentiality of all records and communications concerning your medical history and treatment to the extent provided by law.
- You have a right to a prompt response to all reasonable requests.
- You have a right to request and receive an explanation as to the relationship, if any, of this office and your doctor to any other facility or educational institution, insofar as any such relationship relates to your care.
- You have a right to request and receive information about financial assistance.
- You have a right to obtain a copy of any rules or regulations of this office which may apply to your conduct as a patient.
- You have a right upon request to inspect your records, request an amendment to, or receive an accounting of disclosures regarding personal health information, and for a reasonable fee, receive a copy of your record.
- You have a right to receive a copy of your record free if you show that your request is to support a claim or appeal under any provisions of the Social Security Act in any federal or state financial needs-based benefit program.
- You have a right to refuse to be observed, examined or treated by students or any other staff without jeopardizing your access to care.
- You have a right to personal dignity and, to the extent reasonably possible, to privacy during medical treatment and other care.
- You have the right to have your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- You have a right to prompt life-saving treatment without discrimination due to economic status or source of payment.
- You have a right, if refused treatment for economic status or lack of a source of payment, to prompt and safe transfer to a facility that agrees to provide treatment.
- You have a right to informed consent to the extent provided by law.
- You have a right to request and receive an itemized explanation of your bill.
- You have the right to file a grievance by calling the Operations Director at 413.445.6680, if you have concerns regarding your care and treatment. In addition, you have the right to file a grievance with either the Massachusetts Department of Public Health, Division of Health Care Quality (617-753-8000), 99 Chauncy Street, 2nd Floor, Boston, MA 02111
- You have the right to be informed of your oral health status, be involved in care planning and treatment and be able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically necessary or inappropriate.
- You have the right to formulate advance directives and to have the staff and practitioners who provide care in the office comply with these directives.
- You have the right to access advocacy or protective services and to be free from all forms of abuse and harassment.
- You have the rights to be free from seclusion and restraints of any form that are not necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

- You have the right to have your consent obtained prior to any recording or filming of care treatment and services provided to you which is made for purposes other than the identification, diagnosis or treatment.
- You have the right to be informed about outcomes of care, treatment, and services that have been provided including unanticipated outcomes.
- You have the right to effective communication and to receive information in a manner that you understand.
- You have the right to pain management.

Patients' Responsibilities

As a HDC, Inc patient, we ask that you accept the following responsibilities. This will help us provide the best possible care and will foster an environment of respect and consideration.

- Please give your doctors, hygienists or staff the most accurate information about your medical history, present condition, medications, and other relevant aspects of your health
- If your condition changes or if you feel something is "different" about the way you feel, please tell your doctor or staff right away
- If you experience pain, please tell your doctor or staff and work with them to develop a pain management plan
- Please follow your doctors' and hygienists' instructions. Any requests they make are in the best interest of your health and safety
- If you do not understand or have forgotten the instructions given by your caregivers, ask for clarification
- If you cannot comply with your doctors' or hygienists' instructions, please let them know right away
- Please follow all office regulations
- Please be considerate of the rights of other patients and all members of the HDC, Inc staff
- Please be respectful of others' personal possessions
- Please be respectful of office property
- Please provide accurate health insurance, managed care, or other financial information so we can work effectively with the necessary organizations to process your bill

Any patient who believes that his/her rights have been violated may submit complaints or questions to:

Hillcrest Dental Care, Inc
788 South Street
Pittsfield, MA 01201 413-445-6680

Massachusetts Department of Public Health
Division of Health Care Quality
99 Chauncy Street, Second Floor
Boston, MA, 02111 617-753-8000