Welcome to Mission Valley Dental Clinic

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health

About You

Date ____________________

Home Phone ___________________________
Cell Phone ____________________________
Name ____
Soc. Sec. # _____________________________

Spouse Name ____
(If under 18, Name of parent)
Mailing Address ____

Physical Address (if different) ____

City ____ State ________________________ Zip ___________________

Sex ☐ M ☐ F Age __________ Birth Date _____________________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed By ____________________________________ Business Phone __________________________

Whom may we thank for referring you? ____

In case of an emergency, who should be notified? ______________________________ Phone ____________________

Medical History Update

Physician's (Doctor) Name _______________________________ approx. date of last visit ______________________

Have you had any serious illnesses or operations in last 5 years? ☐ Yes ☐ No If yes, please explain:________________
____

HAS YOUR DOCTOR INSTRUCTED YOU TO PRE-MEDICATE WITH ANTIBIOTICS BEFORE DENTAL APPOINTMENTS? ☐ YES ☐ NO (for joint replacements or mitral valve prolapse)

Medications you're taking (If you have a list we can take a copy)
List prescription medications you are currently taking and what they are for:
____
____

Please check if you're allergic to any of the following:

❑Local anesthetics
❑Sulfa Drugs
❑Codeine/other narcotics
❑Penicillin/other antibiotics __________________
❑Aspirin
❑Latex sensitivity
❑shellfish, iodine or red wine
❑Other ____

Have you ever had a blood transfusion? ☐Yes ☐ No If yes, when ____

Women-are you pregnant? ☐Yes ☐ No If yes, what month are you currently in? ______________________________

Do you smoke? ☐Yes ☐ No If yes, how much? ____

Dental History

Reason for today's visit ___________________________ approx. date of last dental visit_______________________
Check (✓) if you have had problems with any of the following:

☐ Bad Breath
☐ Grinding Teeth
☐ Sensitivity to Sweets
☐ Persistent Bleeding Gums
☐ Sensitivity to Cold
☐ Sores or Growths in Mouth
☐ Clicking or Popping Jaw
☐ Sensitivity to Hot
☐ Dental Anesthetic

How often do you floss? __________________________ How often do you brush? ___________________________

Have you had your wisdom teeth removed? ____________ Have you had orthodontic treatment? __________________

Have you ever had treatment for Periodontal Disease (Pyorrhea)? ________________ When?______________________

Check (✓) if you **have or have had** any of the following:

☐ AIDS or HIV Positive	☐ Cortisone Treatments	☐ High/Low Blood Pressure (circle)
☐ Anemia	☐ Cough, Persistent	☐ Jaw Pain
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Kidney Disease
☐ Artificial Heart Valves:*date:* _____	☐ Diabetes	☐ Liver Disease
☐ Artificial Joints: *date:*_______	☐ Epilepsy	☐ Mitral Valve Prolapse: *date:* __________
☐ Asthma	☐ Glaucoma	☐ Pacemaker: *date:*__________
☐ Back Problems	☐ Persistent Headaches	☐ Radiation Treatment
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Disease
☐ Cancer: *date:*_____	☐ Rheumatic Fever	☐ Scarlet Fever-How Old: __________
☐ Heart Problems__________	Describe __________	☐ Shortness of Breath
☐ Chemotherapy	☐ Hemophilia	☐ Tonsillitis
☐ Circulatory Problems	☐ Thyroid Problems	☐ High Cholesterol
☐ Stroke	☐ Ulcer	☐ Allergies to Latex
☐ Tuberculosis	☐ Hepatitis	☐ Allergies to dental anesthetic

Have there been any new illnesses, serious operations, or blood transfusions since your last health history? ☐ Y ☐ N
If yes, explain ____

Insurance Information

Do you have **DENTAL** insurance? ☐Y ☐N

Primary Insurance Company __________________________ Group # _______________________________________

Insurance Subscriber ________________________________ ID/Soc. Sec. # __________________________________

Employer: ____

If spouse is your policy holder:

Spouse's name: ____ Spouse's birth date: ______/______/_________

Spouse's SS# _____________________________________ Spouse's employer: _______________________________

Is patient covered by additional dental insurance? ☐Yes ☐No

2nd Insurance Company ______________________________ Group # _______________________________________

Insurance Subscriber ________________________________ Soc. Sec. # ______________________________________

Authorization/Informed Consent

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

- I authorize Dr. Ruhkala and assistants to perform the procedures as deemed necessary.
- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges *whether or not* paid by the insurance.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

Signature ____ Date _________________________

Payment and/or insurance co-pay is due in full at time of treatment.

<u>FUTURE UPDATES</u> I have reviewed the current health history and made any changes if necessary.

Signature ____ Date _____________________ ☐changes ☐no changes

Signature ____ Date _____________________ ☐changes ☐no changes