# HEALTH INFORMATION

| | Yes | No |
|---|---|---|
| 1. Have you been hospitalized within the past 2 years? | ☐ | ☐ |
| 2. Are you currently being treated by a physician? | ☐ | ☐ |
| If yes, for what? ______ | | |
| You Phycian's Name: ______ Phone #: ______ | | |
| 3. Are you, or could you be pregnant? | ☐ | ☐ |
| 4. Are you taking or have you recently taken any medicine(s) including non-prescription medicine? | ☐ | ☐ |
| If yes, what? ______ | | |
| 5. Are you allergic to any metals or jewelry? | ☐ | ☐ |
| If yes, what? ______ | | |
| 6. Are you allergic to any drugs? | ☐ | ☐ |
| If yes, what? ______ | | |
| 7. Do you have any other allergies or adverse reactions? (ex: latex, dyes, etc.) | ☐ | ☐ |
| If yes, please explain: ______ | | |
| 8. Do you bleed excessively upon injury? | ☐ | ☐ |
| If yes, please explain: ______ | | |
| 9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ |
| If yes, please list medication: ______ | | |
| 10. Do you smoke? | ☐ | ☐ |
| If so, how many packs per day? ______ | | |
| 11. Do you use smokeless tobacco (chew)? | ☐ | ☐ |
| If so, how often? ______ | | |
| 12. Have you ever received any counseling for excessive use of alcohol and/or prescription drugs? | ☐ | ☐ |
| If yes, please explain: ______ | | |

# MEDICAL CONDITIONS

| | Yes | No |
|---|---|---|
| Abnormal Bleeding | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ |
| Artificial Heart Valves or Joints | ☐ | ☐ |
| Pacemaker or Fibulator | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| If yes, do you carry an inhaler? | ☐ | ☐ |
| Cancer/Chemotherapy/Radiation Tx ______ | ☐ | ☐ |
| Cardiovascular Disease *(if yes, please specify)* ______ | ☐ | ☐ |
| Diabetes *(if yes, please specify)* ____ Type I *(insulin dependant)* ____ Type II | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Hemophilia | ☐ | ☐ |
| Hepatitis, Jaundice or Liver Damage | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Osteoporosis/Medicated | ☐ | ☐ |
| Sexually Transmitted Diseases | ☐ | ☐ |
| High or Low Blood Pressure | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Mental Health Disorders *(if yes, please specify)* ______ | ☐ | ☐ |
| Respiratory Problems *(if yes, please specify)* ______ | ☐ | ☐ |
| Snoring or Stop Breathing at Night | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |

Do you have any disease or condtion not listed above that you think we should know about? Please explain:

______

______

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand this informathion will be used by the dentist to help determine appropriate and heathful dental treatment. **If there is any change in my medical status, I will inform the dentist.**

Signature: X Date:

**Updated Medical History**

Has there been any change in your medical history or new medications from above?

______

______

Signature: X Date:

# Dr. Scott C. Hood, D.D.S & Associates, P.C.

## Confidential Patient Information

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. PLEASE PRINT OR WRITE LEGIBLY.

Date: ____________

### PATIENT'S PERSONAL INFORMATION

Name: ____________ Preferred Name: ____________

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D Spouses Name: ____________

Date of Birth: ____________ S.S.# ____________

Driver's License: ____________ Expires: ____________

Address: ____________
*Street* *City* *State* *Zip*

Email Address: ____________

Telephone - Home: ____________ Cell: ____________

Present Employer: ____________ Business Phone: ____________

Business Address: ____________
*Street* *City* *State* *Zip*

Occupation: ____________ Referred By: ____________

### PERSON RESPONSIBLE FOR DENTAL ACCOUNT - *(indicate if self)*

Name: ____________ Relationship: ____________ S.S.# ____________

Telephone - Home: ____________ Business: ____________ DOB: ____________

### PERSON TO BE CONTACTED IN AN EMERGENCY - *(not living with you)*

Name: ____________ Relationship: ____________ Phone # ____________

### DENTAL INSURANCE INFORMATION & AUTHORIZATION

Primary Insurance Co.: ____________ Phone # ____________

Employer: ____________ Group # ____________

Employee's Name: ____________ Relationship: ____________

S.S.# or Ins. ID# ____________ DOB: ____________

I autorize the insurance company indicated on this form to pay to the dentist 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 services performed whether or not paid by an insurance company.**

Signature: X ____________ Date: ____________

# HOOD FAMILY & COSMETIC DENTISTRY APPOINTMENT CONFIRMATION POLICY

Welcome to Hood Family & Cosmetic Dentistry. We are delighted you've entrusted your dental care to our capable team and look forward to helping you smile for years to come! Our promise to you is to provide you with the best dental care possible in a friendly and professional manner. Dr. Hood's entire team is dedicated to making your dental visit a great experience.

In order to provide you with a positive experience, we ask our patients to be on time for their appointments and, if for some reason they can't make it, provide at least 24 hour notice for all canceled/rescheduled appointments. No show appointments will be billed a non-negotiable fee of $50.

To help with this, we ask our patients to provide an up to date email, cell phone, home phone, work phone and address at all times. This allows our automated system to send notices via email or text when:

1. appointment is scheduled so you can mark your calendar
2. appointment is approximately 1 week out, confirmation request via email. If no confirmation is received and...
3. appointment is a few days out, confirmation request via text
4. appointment is 2 hours out, a friendly reminder text

If the automated system doesn't receive a patient's confirmation via email or text, our front desk team will call them 3 business days out and continue to call them until reached. It's very important Dr. Hood's patients confirm their appointments with us through email, text, or a phone call.

If a patient can't be reached, but does come in for their appointment, they will be worked in, but not guaranteed their original appointment time.

If a patient consistently fails to confirm their appointments through email, text or phone messages, the doctor will still see the patient on a "work-in" basis, but not through scheduled appointments.

Your cooperation with keeping and confirming your appointments is much appreciated.

Thank you.

Dr. Scott Hood & Team

| ____________________ | ____________________ | __________ |
| --- | --- | --- |
| Patient First and Last Name Printed | Patient Signature | Date |

# Hood Family & Cosmetic Dentistry

## HIPAA RELEASE OF INFORMATION AUTHORIZATION

### CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

I have had full opportunity to read and consider the contents of this Consent; and have received your Notice of Privacy Practices. I understand that, by signing, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

### CONSENT FOR ACCESS TO PROTECTED HEALTH CARE INFORMATION

I give consent to the staff at Hood Family & Cosmetic Dentistry to communicate with the person(s) listed below regarding my Dental treatment. I consent to the use of my protected Dental care information when communicating with the person(s) below. Hood Family & Cosmetic Dentistry may communicate in person, by telephone, mail, e-mail, fax or other means. I may withdraw this consent at any time by notifying Hood Family & Cosmetic Dentistry in writing. Any communication prior to such notice will be considered to have been authorized by me. ***If not listed, we are unable to disclose any information without additional written consent.***

PLEASE LIST NAMES OF PERSONS OR FAMILY YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

NAME ________________________________ Relationship to Patient ____________

NAME ________________________________ Relationship to Patient ____________

NAME ________________________________ Relationship to Patient ____________

NAME ________________________________ Relationship to Patient ____________

Patient signature ________________________________ Date ____________

# DENTAL HISTORY FORM

PATIENT NAME: ____________________ (PREFERRED): ____________________ Date: ________

Please describe the primary reason for your visit (concerns):

1 ____________________

2 ____________________

3 ____________________

How long has this been going on and what would you like done?

____________________

____________________

If you could rate your smile from 1 - 10, what would it be? ____________________

Would you like to improve your smile? Y N How? ____________________

____________________

Have you ever suffered from, or been told you may have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Gum Disease | Y | N | Sleep:Snoring/Stop Breathing | Y | N |
| Bruxism or Grinding | Y | N | Bad Breath | Y | N |
| Jaw Pain or TMJ | Y | N | Headaches or Migraines | Y | N |
| Dental Pain | Y | N | Tooth Sensitivity to Hot/Cold | Y | N |

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DOCTOR'S NOTES: ____________________