MERCY
MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○Yes ○No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○Yes ○No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○Yes ○No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	○Yes ○No	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	○Yes ○No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes ○No	_____
Are you on a special diet?	○Yes ○No	
Do you use tobacco?	○Yes ○No	
Do you use controlled substances?	○Yes ○No	

Women: Are you

Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs

❑ Other If yes please explain: _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	○Yes ○No	Cortisone Medicine	○Yes ○No	Hemophelia	○Yes ○No	Radiation Treatments	○Yes ○No
Alzheimer's Disease	○Yes ○No	Diabetes	○Yes ○No	Hepatitis A	○Yes ○No	Recent Weight Loss	○Yes ○No
Anaphlaxis	○Yes ○No	Drug Addiction	○Yes ○No	Hepatitis B or C	○Yes ○No	Renal Dialysis	○Yes ○No
Anemia	○Yes ○No	Easily Winded	○Yes ○No	Herpes	○Yes ○No	Rheumatic Fever	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No	High Blood Pressure	○Yes ○No	Scarlet Fever	○Yes ○No
Arthritis/Gout	○Yes ○No	Epilepsy or Seizures	○Yes ○No	High Cholesterol	○Yes ○No	Shingles	○Yes ○No
Artificial Heart Valve	○Yes ○No	Excessive Bleeding	○Yes ○No	Hives or Rash	○Yes ○No	Sickle Cell Disease	○Yes ○No
Artificial Joint	○Yes ○No	Excessive Thirst	○Yes ○No	Hypoglycemia	○Yes ○No	Sinus Trouble	○Yes ○No
Asthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Irregular Heartbeat	○Yes ○No	Spina Bifida	○Yes ○No
Blood Disease	○Yes ○No	Frequent Cough	○Yes ○No	Kidney Problems	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No
Blood Transfusion	○Yes ○No	Frequent Diarrhea	○Yes ○No	Leukemia	○Yes ○No	Stroke	○Yes ○No
Breathing Problem	○Yes ○No	Frequent Headaches	○Yes ○No	Liver Disease	○Yes ○No	Swelling of Limbs	○Yes ○No
Bruise Easily	○Yes ○No	Genital Herpes	○Yes ○No	Low Blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Cancer	○Yes ○No	Glaucoma	○Yes ○No	Lung Disease	○Yes ○No	Tonsillitis	○Yes ○No
Chemotherapy	○Yes ○No	Hay Fever	○Yes ○No	Mitrial Valve Proplapse	○Yes ○No	Tuberculosis	○Yes ○No
Chest Pains	○Yes ○No	Heart Attack/Failure	○Yes ○No	Osteoporosis	○Yes ○No	Tumors or Growths	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Heart Murmur	○Yes ○No	Pain in Jaw Joints	○Yes ○No	Ulcers	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Heart Pacemaker	○Yes ○No	Parathyroid Disease	○Yes ○No	Venereal Disease	○Yes ○No
Convulsions	○Yes ○No	Heart Trouble/Disease	○Yes ○No	Psychiatric Care	○Yes ○No	Yellow Jaundice	○Yes ○No

Have you had any serious illness not listed above? ○Yes ○No

COMMENTS: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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MERCY MEDICAL CENTER • DENTAL CLINIC

Patient Information			
Patient Name:			Date:
Address:			
City:	State:	Zip:	Phone:
Email Address:			
Birthday:	SS#:		Marital Status:
Race:	Ethnicity:		Drivers License #:
Employer:			
Position:	Emp. Address:		
Emergency Contact:			Phone:
Relationship to Patient:			
Primary Care Physician:			

Primary Dental Insurance		Secondary Dental Insurance	
Name:		Name:	
Policy #:		Policy #:	
Group #:		Group #:	
Subscriber Name:		Subscriber Name:	
Date of Birth:	SS#:	Date of Birth:	SS#:
Employer:		Employer:	

Responsible Party - If different from patient		
Name:		SS#:
Address:		
City:	State:	Zip:
Phone:		Relationship to Patient:

Medical Insurance Information		
Name:		
Policy #:		
Group #:		
Subscriber Name:		
Date of Birth:	SS#:	
Employer:		

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NOTICE OF PRIVACY ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physicians certifications.

I have received, read and understand your notice of Privacy Practices containing a more complete description the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to discuss any and all information related to my care including billing/financial to:

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain patients' signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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MERCY DENTAL SERVICES
PROGRAM PARTICIPATION AGREEMENT

I understand that I am an important member of Mercy Dental Service Team. I understand that to receive continued care for the treatment of my Dental Services, I must agree to the following treatment plan of the Mercy Dental Services. I also understand that Mercy Dental Service works as a team, and I am an important part of that team. Much of the success of my treatment plan depends on my participation. As an active member of Mercy Dental Services, I agree to:

1. Keep scheduled appointments for office visits and any test or treatment ordered by the Mercy Dental Team. If I do not show for three appointments without canceling 24 hours in advance, a $25.00 cancellation fee may be applied to my account, this fee must be paid before I can reschedule. As a result of this I could be terminated from this practice.
2. Follow home instructions for care after my dental services. If I am non-compliant with treatment recommendations, I may be terminated from Mercy Dental Services.
3. Follow recommendations for oral health and hygiene habit changes that will allow for improved oral hygiene.
4. I understand that this office is a fee for service, payment is due day of appointment.
5. I understand that the Dentist at Mercy Dental Services rotates yearly and I may not always receive care from the same dentist.
6. I understand and accept that my appointment times may very as Mercy Dental has unique scheduling and allows for teaching cases, and also emergency treatments. This can cause an appointment to take longer than scheduled.

I further agree to respectfully follow the advice and direction provided by the Dental Team at Mercy Dental Services.

I understand that the Dental Team may have specific recommendations as part of my treatment plan. I also understand that it will be my responsibility to know what procedures are covered under my insurance plan, as my policy is a contract between myself and my insurance company. Mercy Dental Services Staff will help me understand y coverage and process any paperwork that may be necessary to get payment from my insurance company for services rendered.

I understand that I will be encouraged to ask questions about the treatment plan if I do not understand my instructions. This will help promote a better understanding for everyone.

I understand and agree that failure to follow the above may result in my dismissal from the Mercy Dental Services Program.

_____ Date

_____ Patient/Parent/Legal Guardian
(If signed by someone other than the patient, indicate relationship below.)

_____ Witness

_____ Relationship

If patient is unable to sign, indicate reason: _____

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DENTAL X-RAY & IMAGE CONSENT FORM

Dental x-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-ray films detect much more than cavities. For example, x-rays may be needed to survey erupting teeth, diagnose bone diseases, evaluate the results of an injury or plan orthodontic treatment. Photographic images will be necessary for patient identification and verification

If dental problems are found and treated early, before they become visible or painful, dental care is much more comfortable and affordable. Dental x-rays are a part of a comprehensive oral examination.

Please select the below options:

❏ New Dental x-rays may be taken

❏ New photographic images may be taken

❏ I have requested that no photographic images be taken

❏ I have requested that no dental x-rays be taken. I understand that some dental pathology cannot be diagnosed without the use of dental x-rays. I hereby release Mercy Medical Center from responsibility for any oral conditions possibly present of which go undiagnosed as a result of my request that no dental x-rays be made.

_____

Patient Name

_____

Parent/Guardian Signature

_____

Date