

HEALTH QUESTIONNAIRE FOR E-DENTAL GROUP

****CONFIDENTIAL****

Patient's Full Name _____ Preferred Name _____

Patient's Birth Date _____ Social Security _____ Male ___ Female ___

Home Phone _____ Work _____ Cell _____

Address _____ City _____ State ___ Zip Code _____

Email _____ Would you like reminders by email? Y ___ N ___

Patient's Physician _____ Physician's Phone _____

Patient's Dentist _____ Patient's Orthodontist _____

Emergency Contact _____ Phone Number _____

REFERRAL INFORMATION

Whom may we thank for referring you to E-dental? _____

A patient ___ Friend ___ Relative ___ Insurance ___ Web page ___ Yellow pages ___ Newspaper ___

Have you had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Recent illness |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Shortness of breath |
| _____ | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Benign growths | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Bisphosphonate meds.
(fosamax, boniva, actonel) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood vessel grafts | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Immune deficiencies | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney disease | ARE YOU ALLERGIC TO: |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Cortisone/ACTH | <input type="checkbox"/> Low thyroid | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Cough or flu | <input type="checkbox"/> Thyroid removal | <input type="checkbox"/> Eggs or egg whites |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Replacement therapy | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Novocain- local anesthetics |
| <input type="checkbox"/> Difficulty opening | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Penicillin/Amphicillin/Amoxicillin |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> Sulfa drug |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Nervous disorders | Adverse reaction to any other:
_____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Organ transplant | Other health problems not listed:

_____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Pregnancy- currently | |
| | <input type="checkbox"/> Due Date _____ | |

Office Use Only

BP: _____

PR: _____

YES NO

Are you in good health?
Are you having pain or discomfort at this time?
Have you had a bad experience with previous dental or surgical treatment?
Have you been under the care of a physician or hospitalized during the past two years?
If yes, explain _____

Have you ever gone to sleep for an operation? If yes, explain. Any complications? _____

Have you ever had any complications following dental treatment? If yes, explain _____

Have any immediate family members had a serious reaction to a general anesthetic? _____

Are you taking medicines of any kind, including aspirin, diet pills or vitamins? Please list: _____

Have you ever used recreational or IV drugs (marijuana, cocaine, etc.) or Phen/Fen? Please list: _____

Do you smoke or use smokeless tobacco? If yes, how long _____ How much per day? _____

Do you wear dentures/partials?

Do you wear contacts?

Have you undergone eye surgery in the past 8 weeks?

Do you have a specific dental problem you would like to address? _____

Do you have dental exams on a regular basis?

Are your teeth sensitive to: cold _____ hot _____ sweet _____ biting _____ touch _____

Do you think you have active decay?

Do you think you have gum disease?

Do your gums bleed?

Have you been taught how to control gum disease?

Do you brush your teeth? How often: twice daily__ once daily__ weekly__ not regularly__

Do you floss your teeth? How often: twice daily__ once daily__ weekly__ not regularly__

Have you had: scaling or root planing__ gum surgery__ TMJ therapy__ surgery__ braces__

Do you clench or grind your teeth?

Do you wear a grinding guard/night guard?

Do you have clicking or popping in your jaw joint?

Do you have human papillomavirus (HPV) or a history of HPV?

Do you have any sores, ulcers or growths in your mouth? _____

Do you drink alcoholic beverages? If yes how often? Never__ seldom__ more than 2 a day__

Do you have fear of dental treatment?

Are you pleased with the appearance of your teeth?

Would you like to have your teeth whitened?

Do you think you have bad breath?

Are you under the care of a Physician? Please explain: _____

Describe any other changes you would like in the appearance of your teeth: _____

Do you have any other information you think we should know about? _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in health status, or if my medications change, I will inform the doctor accordingly.

Patient Signature: _____

If Minor, relationship to patient: _____

Dentist Signature: _____

RESPONSIBLE PARTY INFORMATION

Full Name _____ Date _____

Social Security Number _____ Birth Date _____

Home Phone _____ Cell _____ Work _____

Address, if different than patient's _____

EMPLOYMENT INFORMATION

The Following is for: The Patient _____ or The Person Responsible for Payment _____

Employer Name _____ Occupation _____

Address _____

INSURANCE INFORMATION

Primary name of Insured _____ Is insured a patient? yes no

Patient's relationship to Insured? Self Spouse Child Other

Insured's Birth date _____ ID # _____ SS# _____ Group # _____

Insured's Address _____

Insurance Plan Name and Address _____

_____ Ins. Co. Phone Number _____

Secondary

Name of Insured _____ Is insured a patient? yes no

Patient's relationship to Insured? Self Spouse Child Other

Insured's Birth date _____ ID # _____ SS# _____ Group # _____

Insurance Plan Name and Address _____

_____ Ins. Co. Phone Number _____

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our financial administrator depending upon special circumstances. An estimate of charges for any procedure will be given to you upon request. If you have insurance, we will be happy to submit the claims, but it is your responsibility to provide the needed information. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor, and it is not a substitute for payment. Some companies pay fixed allowances for procedures while other companies pay a percentage of their allowance. It is your responsibility to pay any deductible, co-payment, percentage of charges your insurance does not cover.

This signature on file is my authorization for the release of information necessary to process my claim, and provide information and/or x-ray copies to my referring doctor (s) regarding my treatment. I hereby authorize payment directly to the doctors named on the insurance benefits, otherwise payable to me. If I fail to pay as promised, I agree to pay all reasonable costs and attorney fees. I have read the Patients' Rights and Responsibilities Statement.

SIGNATURE _____ DATE _____

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 THIS 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 (MM/DD/YR) 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.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. 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 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 qualification 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 anytime. Your revocation will not affect any use or disclosure 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 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.

Person 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, or 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 a 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, 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 \$25.00 to cover the cost of each page, and 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 structures.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for the 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.

Restrictions: 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 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 website 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.

Contact Officer: Althea A. Eggleston, DDS, PA or Dr. Todd I. Eggleston DDS

Telephone: 512-637-8989 **Fax:** 512-391-0031

Address: 1209 W. 5th Street, Suite #100 Austin, TX 78703

ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

I have been made aware of the HIPPA Privacy Practices Notice for E Dental Group at 1209 W. 5th Street, Suite #100-B.

X _____
Print Name of Patient Date

X _____
Signature of Individual Date

X _____
Or Representative/Relationship to Individual Date