HEALTH HISTORY

Name: ______________________________ Date: ____________ D.O.B.: ____________

Address: ______________________________ City: ____________ Zip Code: ____________

Phone: ______________ Cell: ______________ e-mail: ______________

Person Responsible for payment: ______________________________ Business Phone: ____________

Employed by: ______________________ Business Address: ______________________

Date of last health care exam: ____________ What was this exam for? ______________________

Have you been hospitalized in the last 5 years? ❑ Yes ❑ No If yes, reason: ______________________

Are you currently receiving care? ❑ No ❑ Yes If yes, nature of care: ______________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ______________________ ______________
2. ______________________ ______________
3. ______________________ ______________
4. ______________________ ______________

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma?	No	Yes	Kidney Disease?	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)?	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes?	No	Yes
Diabetes?	No	Yes	Psychosis?	No	Yes
Emphysema or other Respiratory/Lung Illnesses?	No	Yes	Previous Biopsies?	No	Yes
Epilepsy?	No	Yes	Radiation or Chemotherapy Treatment?	No	Yes
Fainting or Dizzy Spells?	No	Yes	Rheumatic Fever?	No	Yes
Glaucoma?	No	Yes	Slow-Healing Mouth Sores?	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis?	No	Yes	Unintentional Weight Loss/Gain?	No	Yes
Heart Valve (artificial) or Heart Transplant?	No	Yes	H.I.V. Infection/AIDS or ARC?	No	Yes
Congenital Heart Disease?	No	Yes	Venereal Disease?	No	Yes
Heart Disease, Heart Attack, Heart Surgery?	No	Yes	Other Conditions?	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses?	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®?	No	Yes	Serzone® (nefazodone)?	No	Yes
Barbiturates (any)?	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (claithromycin)?	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

Women: Are you Pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Abnormal Blood Pressure? (Please circle)		
Have you ever received a diagnosis of "high blood pressure"	No	Yes
What is your normal blood pressure? S / D Today: /		

Are you allergic or have you had a reaction to:		
a. Local anesthetics	No	Yes
b. Penicillin or other antibiotics	No	Yes
c. Aspirin, Ibuprofen or Tylenol	No	Yes
d. Codeine, Valium® or other sedatives	No	Yes
e. Latex or Metals	No	Yes
f. Other (please specify)		

Tobacco, Alcohol, Drugs

Do you us tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations (for medication, sedation use)

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (Circle one): none slight moderate high

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) *Patient Signature* *Date*

Doctor (Print Name) *Doctor Signature* *Date*

OFFICE POLICIES

Appointments: When canceling appointments we request your courtesy in providing us 24 hour notice. We sometimes find it necessary to charge for broken/canceled appointments as the office incurs expense whether you are here or not. This fee is $50 per half-hour of scheduled time.

Insurance: Our office participates with Delta Dental of Rhode Island Premier Plan and Blue Cross of Rhode Island. We will file your claims as a courtesy regardless of your carrier. Any estimated portion of payment will be collected on the date of service. Since employers change insurance carriers regularly and each carrier offers a variety of plans, please be aware that you as the patient are ultimately responsible for knowledge of your policy as well as costs not covered by the insurance company.

Authorization and Release: To the best of my knowledge, the health history I have provided is correct. I certify that I, and/or my dependents, have dental insurance coverage and assign payments directly to Dr. Phillip C Barner DDS/ Dr Gregory Barner DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Outstanding Balances : For any delinquent and outstanding balances or monies owed to this office, plus applicable interest, the patient or person responsible for this account will also be responsible for any and all costs to recover said monies including, but not limited to: collection agency fees, court fees, sheriff fees, lost billable hours associated with the Doctor's appearance in court, and all applicable attorney fees.

HIPAA Compliant: Our office respects your privacy, and we take every measure to protect the information you give us.

I have read and understand the above.

Signature:________________________________ Date:_________________________

PATIENT 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. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this____ day of ___________, 20___.

Print Patient Name: ______________________________

Relationship to Patient: ___________________________

Signature: _____________________________________

Practice Name: BARNER DENTISTRY GROUP, LLC

Address 550 Douglas Pike

City/State/Zip Smithfield, RI 02917