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?

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

Have you ever 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 ____________

McGovern Family Dentistry

Justin H. McGovern, DMD
1370 W. Gordon St. Douglas, GA 31533 • (912) 384-1306

RESPONSIBILITY OF ACCOUNT

Welcome to McGovern Family Dentistry! Should you have a dental benefit plan that you would like for us to check on to help you with your dental expenses, please provide that information at your appointment. In all cases, it is our intent to fully explain and inform you of all procedures, options, and fees associated with treatment, in advance. After your initial exam, we can provide you with a treatment plan which estimates your portion of payment. If your benefit plan contributes less, you will be responsible for the difference. All fees associated with treatment are due at the time services are rendered. We accept cash, credit card, and Care Credit for payment.

Please be advised that we can only estimate what your dental benefit plan will contribute to the cost of your treatment. In addition, some necessary services may not be covered by your plan. If there is a balance remaining after your dental benefit plan has paid their portion, you will be responsible for paying it within 14 days. Payment inactivity on your balance for 60 days will result in further collection action. This may involve a third party collection agency that may report your unpaid balance to all three credit bureaus. If your account needs to be turned over to a third party for collection, there may be additional charges added to your account to cover collection agency fees or any legal fees.

BROKEN APPOINTMENT / CANCELLATION POLICY

Missed or broken appointments waste valuable time and may put you at risk of infection. A broken appointment interferes with the doctor's ability to properly complete the planned treatment which has been scheduled for you. We do require 48 hours notice to cancel or reschedule an appointment. Any combination of failing to give adequate cancellation notice or not showing for 3 appointments in a 12 month time period will result in dismissal from McGovern Family Dentistry. Patients who have been dismissed will receive a written notification and will be seen for emergency care only for 30 days from the date of the dismissal letter.

CONSENT TO TREATMENT

I hereby give consent to McGovern Family Dentistry to provide treatment to myself or the listed patient in which I am the parent/guardian/caretaker. I consent to any x-rays, examinations, or other dental treatments rendered under general, direct supervision of any dentist associated with McGovern Family Dentistry and/or staff members, as the doctor may deem necessary.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information, please do not hesitate to ask.

By signing below, you indicate that you have read, understand, and agree to comply with the policies listed above.

This form will be signed on the Electronic Signature Pad at the front desk.

Signature of the Patient/Parent/Guardian

McGovern Family Dentistry

Justin H. McGovern, DMD
1370 W. Gordon St. Douglas, GA 31533 • (912) 384-1306

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMAITON

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

The Health Insurance Portability & Accountability Act

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and healthcare operations as we see need at our discretion and as stated in our ÷HIPAA Notice of Privacy Practices ó Last updated: January 2011 versionø
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1. Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilitarian review. For example, we disclose treatment information when billing a dental plan for your dental services.
3. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to the practice address listed above.

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, others relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to request to receive confidential communications of protected health from us by alternative means or at alternative locations.
3. The rights to access, inspect, and copy your protected health information.
4. The right to request an amendment to your protected health information.
5. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
6. The right to obtain a paper copy of this notice from us upon request.

By signing below, I understand and agree to the above information and agree that I have had the opportunity to review the office's HIPAA Notice of Privacy Practices (Last updated: January 2012 version). A full copy of the officeøs õHIPAA NOTICE OF PRIVACY PRACTICESö can be obtained from the front desk.

This form will be signed on the Electronic Signature Pad at the front desk.

Signature