G. GRABER DDS

COSMETIC & IMPLANT DENTISTRY

DENTAL HISTORY FORM

What is your immediate concern? _____

Have you lost any teeth? **Y/N** How?_____

Have you ever had or currently have growths or swelling in your mouth? **Y/N** Where? _____

Do you avoid brushing any area of your mouth? **Y/N** Why?_____

Do you catch food between your teeth? **Y/N** Where? _____

Do you have dry mouth or lack of saliva? **Y/N**

Have you ever been told you have gum/periodontal disease? **Y/N** _____

Do you have any areas of discomfort in your mouth? **Y/N** Where?_____

Do you ever experience sore or stiff neck muscles? **Y/N** How often?_____

Is your jaw painful or locked when you get up in the morning? **Y/N** _____

Do you notice that you clench you teeth during the daytime hours? **Y/N** How often?_____

Do you or have you ever been told that you grind your teeth at night? **Y/N**

Do you have grating, clicking, cracking, or popping sounds in either or both joints when you chew or open your mouth? **Y/N**

Do you have difficulty chewing your food? **Y/N**

Have you ever experienced trauma to the chin, face, or head? **Y/N** When?_____

Do you have an unpleasant taste or odor in your mouth? **Y/N**

What are your parents' dental histories? Mother_____Father_____

How would you rate the appearance of your teeth? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Do you want to learn how to control dental disease and retain your teeth? **Y/N**

What can we do to make your dental visits more pleasant?_____

What would you change about your mouth if you didn't have any obstacles?_____

What might those obstacles be?_____

Would you like your teeth pearly white and perfect or natural with pleasing irregularities?_____

How important is it for you to keep your teeth healthy, comfortable, and aesthetic for the rest of your life? _____

_____

Do I have permission to tell you all of your dental needs? **Y/N**

Are you currently undergoing treatment with a dental specialist? **Y/N** Whom?_____

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ADA. American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: _____ Home Phone: ( ) _____ *Business Phone:* ( ) _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M ❑ F ❑

SS#: _____ Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

If you are completing this form for another person, what is your relationship to that person?
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain: _____

How would you describe your current dental problem? _____

Date of your last dental exam: _____

Date of last dental x-rays: _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated? _____

Date of last physical examination: _____

Physician: _____
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem? _____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements: _____

	Yes	No	Don't Know
Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours? _____

In the past week? _____

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list: _____

Frequency of use (daily, weekly, etc.): _____

Number of years of recreational drug use: _____

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) _____	☐	☐	☐
Other (specify) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction. _____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
If yes, when was this operation done? _____			
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? _____			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
If yes, what antibiotic and dose? _____			
Name of physician or dentist*: _____			
Phone: _____			

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes, date: _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:	☐	☐	☐
____ Angina ____ Heart murmur			
____ Arteriosclerosis ____ High blood pressure			
____ Artificial heart valves ____ Low blood pressure			
____ Congenital heart defects ____ Mitral valve prolapse			
____ Congestive heart failure ____ Pacemaker			
____ Coronary artery disease ____ Rheumatic heart			
____ Damaged heart valves disease/Rheumatic fever			
____ Heart attack			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosurpression	☐	☐	☐
Diabetes. If yes, specify below:	☐	☐	☐
____ Type I (Insulin dependent) ____ Type II			
Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders. If yes, specify: _____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	☐	☐	☐
____ Emphysema ____ Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐
Please explain: _____			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

G. GRABER DDS

COSMETIC & IMPLANT DENTISTRY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The United States Department of Health and Human services, effective August 9, 2002, issued comprehensive federal regulations providing for protection of private medical information with which our office must comply. The final regulation, which goes into effect April, 2003, is designed to protect patient's identifiable health information. These protections are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (if more stringent state laws exist, these must be observed).

The HIPAA privacy rule states that after April 14, 2003, health providers must provide patients with a written Notice of Privacy practices and make a good faith attempt to obtain written acknowledgement of such. This information should be provided to patients prior to or at the time of the first delivery of health services, except in cases of emergency. However, if a written acknowledgement is not obtainable, the attempt by the provider to obtain it is sufficient to comply with the rule.

In addition a Notice of Privacy Practices must be displayed prominently and available, for the patients to take home. If this notice is modified in the future, the new version must be displayed and available, and therefore provided to the patients at the time of their first treatment.

Requires language from the Department of Health and Human Services Standards for the Privacy of Individually Identifiable Health information: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

The Health Insurance Portability and Accountability Act of 1996 requires that the health providers keep your medical and dental information private. The HIPAA privacy rule states at health providers must also provide patients with a written Notice of Privacy Practices. This notice is dated 2/15/2003. The Privacy Practices described will be in effect after this date. And until or if they are replaced. Our office privacy Practices may change from time to time. If changes are made, a new Notice of Privacy Practices will be displayed and provided to our patients. You may obtain additional copies of this Notice upon request. Additional information may be obtained by the Contact Officer listed on this notice.

USES AND DISCLOSURE OF INFORMATION

(from Department of Health and Human Services. Standards of Privacy of Individually Identifiable Health Information, Parts 160-164) The following describes how information may be used.

TREATMENT SERVICES

We may use or provide your health information to all of our staff members, lab technicians, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointments reminders, recommendations of treatment alternatives, information about other heath services and/or other office services. We do post daily schedules in the operatories, including name, phone contact, and treatment to be rendered.

PAYMENT AND OPERATIONS

We may provide your health information as required to allow for payment of services and participation in quality assurance, disease management, training, licensing, and certification programs.

MARKETING

We will not use your health information for marketing purposes without written consent.

LEGAL REQUIREMENTS

We may disclose your health information when required by law.

THREAT TO HEALTH AND SAFETY

If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

NATIONAL SECURITY

When required, we may disclose military personal health information to the Armed forces. Information may be given to authorized federal officials when required for intelligence and national security activated. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.

FAMILY MEMBERS, FRIENDS, AND OTHERS INVOLVED IN CARE

At your request, we may disclose our health information to a family member of other person if necessary to assist with treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we a may disclose your information to these persons in the event of an emergency situation, We also my make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may ne disclosed to assist in notifying a family member, care giver, or personal representative of your location, condition, or death.

PATIENT RIGHTS

You have the right to see your information and receive copies of your records under most circumstances. Your request must be addressed in writing addressed to the contact officer listed on this notice. You may be charged for the cost of making copies including the actual copies and the staff's time. Postage will be added if request of copies are asked to be mailed. A summary of your health information can also be requested for a fee. Details of all costs are available from our contact officer.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last years, but not before April 14, 2003. You may be charges for casts associated with our responses.

You may request that we observe additional restrictions on the discloser of your information. We are not required to agree to these restrictions, be we may do so (except in case of an emergency).

If you believe that changes should be made to your health information, you must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified of at a specified location you must make your request in writing.

PATIENT AUTHORIZATIONS

You may give us your written authorization to use or disclose your health information to anyone for any purpose. This authorization may be revoked, in writing, at any time. Without your written authorization, disclosures about your health information are limited to those listed in the Notice.

QUESTIONS AND COMPLAINTS

If you have a complaint pr need more information about our privacy practices please let is know. Your complaint may be related to a perceived violation or your privacy rights, access to your health information, requested changes in your records, or for ay other reason. If you want to submit a written complaint to the U.S. Department of Health and Human Services we can provide you with the address. We completely support your right to privacy and will not retaliate should you decide to lodge a complaint.

Contact officer: Dr Graber

Acknowledgement of Receipt of
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain acknowledgement of receipt of the same: *You may refuse to sign this acknowledgement form.*

By signing this form I confirm that I have received a copy of the office Notice of Privacy Practices.

If there is a person you would like us to share your personal healthcare information and financial account status with please write the name (s) here: _____

Print name: _____

Sign Name: _____

Date: _____

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Cancellation Policy

If you unable to keep an appointment, we expect a verbal 24 hour notice prior to the scheduled start time of your appointment. Failure to do so will result in a fee of $75.00 per cancellation. After one failed/short notice cancellation occurs, you may be asked for a pre-payment prior to scheduling services.

Signature_____ Date_____

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Consent to Treatment

TREATMENT TO BE DONE – I understand and consent to have any treatment done by the Dentist after the procedure, the risks, the benefits and the costs have been fully explained. These treatments include, but are not limited to x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, and/or dentures.

Initial _____

DRUGS AND MEDICATION – I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

Initial _____

CHANGES IN TREATMENT PLAN – I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initial _____

REMOVAL OF TEETH – I understand that there are alternatives to tooth removal (root canal therapy, crowns, and periodontal surgery, etc.) and agree to completely understand these alternatives, including their risks and benefits prior to authorizing the Dentist to remove teeth and any others necessary for reasons as above. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initial _____

CROWNS (CAPS), LAMINATES, AND BRIDGES – Preparing a tooth may irritate the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold or pressure. Treating such irritation may involve using special toothpastes or mouth rinses or root canal therapy. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation, and I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before permanent cementation.

Initial _____

ENDODONTIC TREATMENT (ROOT CANAL) – I understand that there is no guarantee that root canal treatment will save a tooth, and that complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses occurring in their manufacture and calcifications present in teeth can cause them to break during use. I understand that referral to an Endodontist for additional endodontic treatments may be necessary following any root canal treatment, and I

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agree that I am responsible for any additional costs for treatment preformed by the Endodontist. I understand that a tooth may require extraction in spite of all efforts to save it.

Initial _____

PERIODONTAL DISEASE – I understand that periodontal disease is a serious condition causing gum and bone inflammation and/or loss and that it can lead to the loss of my teeth. I understand the alternative treatment plans to correct periodontal disease, including gum surgery, tooth extractions with or without replacement. I understand that following scaling and root planning treatment, periodontal surgery, and laser treatment. Additional treatment such as periodontal surgery may be required. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initial _____

FILLINGS – I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling or a crown may be required, as additional decay or fractures may become evident after-initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newly placed filling. I further understand that filling a tooth may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy.

Initial _____

DENTURES – I understand that wearing of denture can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. A permanent reline will be needed later, which is not included in the denture fee. I understand that all adjustments are included in the denture fee for a period of six months from the date of delivery, and that any and all adjustments or alterations of any kind and after this initial period are subject to charges.

Initial _____

WHITENING – I understand that whitening compound chemical may cause irritation of gum tissue. I understand that significant sensitivity is a common, but usually temporary, after effect of whitening. I further understand that whitening may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy.

Initial _____

PHOTOS – I consent to having photographs taken. I understand that the images may be used for all purposes and in all media including, without limitation, brochures, advertisements, and other promotional materials. Examples include office records, lab communication, lectures, before and after photos displayed in the office and online. I represent that I am eighteen years of age or older.

Initial _____

I understand that dentistry is not an exact science and that no dentist can properly guarantee results.

I hereby authorize any of the dictions or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage (except covered AHCCCS fees) I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fee, or court costs that may be incurred to satisfy any obligation to this office.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Doctor Signature Date

_____ _____

Witness Signature Date

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