Judy H. Huey D.D.S
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Date _____

Patient Name _____ Preferred Name (if different) _____

Address _____

City _____ Zip _____

Telephone: home _____ work _____ cell _____

E-mail address _____ Employer _____

Occupation _____ S.S # _____ Date of birth _____

Spouse's/Parent's name _____

Address (if different) _____

Occupation _____ Employer _____

Do you have dental insurance? **Yes** **No** Insurance company _____
Group# _____ ID# _____

Named of insured person _____ SS# of insured person _____

Date of birth of insured person _____

Who recommended you to us? _____

HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question): ----------

Yes No Is your general health good?
Yes No Has there been a change in health within the last year?
Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
Yes No Are you being treated by a physician now?
For what? _____
Date of last medical exam _____

II. HAVE YOU EXPERIENCED? ----------

Yes	No	Chest pain (angina)?	Yes	No	Seizures?
Yes	No	Swollen ankles?	Yes	No	Frequent urination?
Yes	No	Shortness of breath?	Yes	No	Excessive thirst?
Yes	No	Blurred vision?	Yes	No	Dry mouth?
Yes	No	Sinus problems?	Yes	No	Jaundice?
Yes	No	Difficulty swallowing?	Yes	No	Joint pain, stiffness?
Yes	No	Dizziness?	Yes	No	Recent weight loss, fever, night sweats?
Yes	No	Ringing in ears?	Yes	No	Bleeding problems, bruise easily?
Yes	No	Fainting spells?	Yes	No	Headaches?

III. DO YOU HAVE OR HAVE YOU HAD? ----------

Yes	No	Heart disease?	Yes	No	Arthritis, rheumatism?
Yes	No	Rheumatic fever?	Yes	No	Herpes?
Yes	No	Heart attack, heart defects?	Yes	No	AIDS, ARC or HIV?
Yes	No	Stroke,hardening of the arteries?	Yes	No	Eye disease?
			Yes	No	Skin disease?
Yes	No	Heart murmurs?	Yes	No	High blood pressure?
Yes	No	Tumors, cancer?	Yes	No	Anemia?

Yes	No	Diabetes?	Yes	No	Family history of diabetes or heart problems?
Yes	No	VD (syphilis or gonorrhea?)			
Yes	No	Stomach problems, ulcers?	Yes	No	ALLERGIES: to foods latex,medications? please list _____
Yes	No	Kidney, bladder disease?			
Yes	No	Thyroid, adrenal disease?	Yes	No	TB, asthma,emphysema?
			Yes	No	Hepatitis, other liver disease?

IV. DO YOU HAVE OR HAVE YOU HAD?

Yes	No	Psychiatric care?	Yes	No	Surgeries?
Yes	No	Hospitalization?	Yes	No	Prosthetic heart valve?
Yes	No	Radiation treatments?	Yes	No	Pacemaker?
Yes	No	Blood transfusion?	Yes	No	Artificial joint?
Yes	No	Chemotherapy?	Yes	No	Contact lenses?

V. ARE YOU TAKING?

Yes	No	Recreational drugs?	Yes	No	Tobacco in any form?
Yes	No	Alcohol?			
Yes	No	Drugs, medicines (including aspirin or vitamins)? Please list _____			
Yes	No	Have you ever taken prescription medication for weight reduction (DIET PILLS)? If "yes," did you take any of the below listed drugs? (Please indicate with an X on line) ___ Fen-Phen (fenfluramine-phentermine) ___ Pondimin (fenfluramine) ___ Redux (dexfenfluramine)			
Yes	No	If you have taken any of the above drugs, have you had a medical exam to insure that your heart valves were not affected?			

VI. WOMEN ONLY

Yes	No	Are you or could you be pregnant or nursing?
Yes	No	Taking birth control pills?

VII. ALL PATIENTS

Yes	No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain _____

VIII. DENTAL HISTORY

Previous Dentist _____ Date of last dental examination _____

Date of last full-mouth x-rays (18 films) _____

Yes	No	Have you had problems with prior dental treatment?
Yes	No	Are you in pain now?
Yes	No	Do your gums feel tender or swollen?
Yes	No	Do you lose fillings or break fillings?
Yes	No	Do you gag easily?
Yes	No	Have you ever had orthodontic treatment?
Yes	No	Do you like your smile? If not, what would you like to change about it? _____ _____
Yes	No	Do you snore?
Yes	No	Do you wake up "gasping for breath?
Yes	No	Have you ever been diagnosed or do you suspect you have sleep apnea?

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Huey or my hygienist of any change in my health and/or medication.

Patient's signature _____ Date: _____

Date _____

AUTHORIZATION AND RELEASE TO DIAGNOSE & TREAT

1. I certify that the answers to the dental and health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or in medications can affect dental health and treatment, I understand the importance of and agree to notify _____ or staff of any changes at any subsequent appointment.

2. I hereby authorize _____ or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, and to employ such assistance as required in order to provide proper care.

3. Upon such diagnosis, I authorize _____ to perform those procedures agreed upon and deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, and to employ such assistance as required in order to provide proper care.

4. I agree to the administration of any local anesthetic, sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic, or surgical treatments that are deemed necessary or advisable.

5. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, temporary or, rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks associated with general preventative, operative, surgical, cosmetic, or TMJ treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures, if necessary, will be explained to me and I will be given the opportunity to ask questions.

6. I authorize _____ to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

7. I understand that I am solely responsible for all treatment decisions for myself or any minor child or ward, regardless of insurance coverage. I understand that diagnosis and treatment recommendations will not be based upon what insurance dictates, but that all treatment recommendations will be, in the doctor's professional opinion, the best, most conservative, and most effective long-term options available.

Patient (or responsible party) Signature _____Date _____

OUR FINANCIAL POLICY

1. Fees for services are due and payable at the time treatment is rendered. We accept cash, personal checks, Visa, MasterCard, or debit cards.

2. **There will be a $100 administrative fee for missed appointments and last minute (less than 48 hours) cancellations/reschedules or changes in treatment planned.** *Appointment times are reserved specifically for you and must be treated as a serious obligation.* Any last minute change in appointment scheduling affects *many* people. Missed appointments/ cancellations disrupt the timely delivery of necessary treatment for you and interfere with the scheduling of treatment for our other patients. In addition, each member of our dental team takes great care in planning for your visit devoting a great deal of time and attention in preparing the operatory, instruments and materials *specifically for you and the planned treatment.* Intensive study of your radiographs, models, occlusion and that day's specifically planned treatment are required prior to each new session with you. Please assist us in providing optimal and timely treatment to all patients by confirming and keeping your appointment.

3. Failure to keep your account current will prevent our being able to continue to provide additional dental services to you except in an emergency dental situation. We value our doctor-patient relationship with each patient and desire to provide the best care possible. However, in order to continue to provide this care we must receive payment for services rendered.

4. In the event of default on your account, you agree to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

5. There is a $45 fee for any returned check.

6. For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The *insurance relationship constitutes an agreement between the carrier and the patient.* As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Person Responsible For This Account: _____ Relationship to Patient: _____

___I authorize and hereby request my insurance company to pay directly to _____ insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. ***I understand that it is my responsibility to know my insurance benefits.***

___I authorize _____to release all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependants whether or not paid by insurance. Fees are due when services are rendered.

___I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment; insurance companies *never* guarantee coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office *regardless* of estimated insurance reimbursement. Possession of insurance coverage does not negate this responsibility

___Any insurance claim not paid in full after 30 days (from date of service) will become *my responsibility to pay immediately despite status of pending insurance claim.* Any insurance payments made after my payment will be applied as follows: 1) used to pay off any outstanding debt on my/family account; 2) credited to my account for future treatment or reimbursed directly to me.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment or accepting appointment.

Patient (or responsible party) Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices; Instructions for Discussing Personal Health Information

Judy Huey DDS, PC

I have received and reviewed a copy of this office's Notice of Privacy Practices.

Instructions for Discussing my Personal Health Information with Others

I give permission to the office of Judy Huey DDS, PC to discuss my personal health information with the following individuals:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature:_____

Date:_____