

**CONFIDENTIAL PERSONAL & MEDICAL HISTORY**

Name Mr., Mrs., Miss, Ms., Dr.: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_ Sex \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Regular Dentist \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

Physician \_\_\_\_\_ Your general health (circle one): Good Fair Poor

In case of emergency, whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name and birthdate \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_

Primary Dental Insurance \_\_\_\_\_ Policyholder/ID# \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_ Policyholder/ID# \_\_\_\_\_

Are you here because of an accident? YES NO

Is this a Workman's Compensation claim? YES NO

Pharmacy Preference \_\_\_\_\_

NOTE: We will assist you in providing documentation of fees for services provided.  
You are responsible for all charges and for obtaining reimbursement from the insurance company.

Have you traveled outside of the U.S. in the last 6 months? YES NO

Please check any of the following conditions that you have had or have at present:

- |                                 |                                    |                             |                        |
|---------------------------------|------------------------------------|-----------------------------|------------------------|
| _____ AIDS/HIV                  | _____ Cortisone Therapy, long term | _____ Heart                 | _____ Liver Disease    |
| _____ Alzheimers Disease        | _____ Diabetes                     | _____ Artificial Valve      | _____ Lung Disease     |
| _____ Artificial Joint          | _____ Drug/Alcohol Addiction       | _____ Heart Attack/Stroke   | _____ Psychiatric Care |
| _____ Asthma                    | _____ Epilepsy or seizure disorder | _____ Murmur                | _____ Sinus Conditions |
| _____ Cancer/Type               | _____ Hemophilia                   | _____ Mitral Valve Prolapse | _____ Thyroid Disease  |
| _____ Chemotherapy              | _____ Hepatitis A B C              | _____ Pacemaker             | _____ Tobacco Use      |
| _____ Radiation                 | _____ Jaw Problems                 | _____ Rheumatic Fever       | _____ Tuberculosis     |
| _____ Cold Sores/Fever Blisters | _____ Kidney Disease               | _____ High Blood Pressure   |                        |

List any diseases, conditions or problems not noted above \_\_\_\_\_

Are you taking oral or IV medication for osteoporosis? YES NO Drug Name \_\_\_\_\_

List any other medicine or drugs you are presently taking \_\_\_\_\_

Are you allergic to any medicine, drug or other substance? YES NO If yes, what? \_\_\_\_\_

Have you ever had a complication during or after dental treatment? YES NO If yes, what? \_\_\_\_\_

Have you ever had an injury to your face or jaw? YES NO If yes, what? \_\_\_\_\_

Is there anything else about your physical condition you think we should know? \_\_\_\_\_

WOMEN: Are you pregnant? YES NO Due date \_\_\_\_\_ Nursing? YES NO Using birth control? YES NO

*To the best of my knowledge, all of the preceding answers are true and correct. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY DR. MEIER. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement I have with my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including, but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorizes payment sent directly to Dr. Meier.*

Date \_\_\_\_\_ Signature of Patient, Parent, Guardian or Responsible Party \_\_\_\_\_

FOR OFFICE USE: HIPPA Consent obtained \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES/ USE AND DISCLOSURE FORM**

**Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.**

**By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.**

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Patient	Legal Relationship to the Patient <i>(If required)</i>

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

**I give you permission to share my health information with:**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Consent to email or text for appointment reminders and other healthcare communication.**

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is \_\_\_\_\_. Please initial \_\_\_\_\_

The email address that I authorize to receive email messages for appointment reminders and general health information is \_\_\_\_\_. Please initial \_\_\_\_\_

Or

\_\_\_\_ I **decline** to receive communications via **text**.

\_\_\_\_ I **decline** to receive communications via **email**.

**Revocation** - Use this area to document revocation of a previous form of communication.

\_\_\_\_\_ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

\_\_\_\_\_ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature \_\_\_\_\_ Date requested: \_\_\_\_\_

*Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

*This form does not constitute legal advice and covers only federal, not state, law.*

Click **SUBMIT** button to send your completed form to our office (only works in Adobe Acrobat).  
If you're having problems, please give us a call at 812-333-6363.

**SUBMIT**