



**Consent for Use and Disclosure of Health Information  
Health Insurance Portability Accountability Act (HIPAA)**

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**By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A staff member can provide you a copy of this Consent, we encourage you to read.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Dr. Sara Cummins.

**Patient Giving Consent**

I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)  
\_\_\_\_\_ (relationship to patient, if parent or guardian)

**Patient Revoking Consent**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)  
\_\_\_\_\_ (relationship to patient, if parent or guardian)

**Notice of Privacy Practices**

I acknowledge that I have been notified that our NOTICE OF PRACTICE POLICIES can be obtained via our office. This document is printable via the website for your records.

HIPAA website: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

(You may refuse to sign this acknowledgement)

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)

For office use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other \_\_\_\_\_

## Medical Health History

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Patient's Name \_\_\_\_\_ Are you currently under the care of a physician? Yes or no

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

*Please indicate any condition that you have had in the past or have now by circling either YES or NO and fill in the blank space when indicated.*

### CARDIOVASCULAR

Heart Failure Yes No  
 Heart Disease or attack Yes No  
 Angina pectoris or chest pains Yes No  
 High blood pressure Yes No  
 Heart murmur or click Yes No  
 Mitral valve prolapse Yes No  
 Rheumatic fever Yes No  
 Congenital heart defect or lesion Yes No  
 Heart surgery or transplant Yes No  
 Artificial heart valve Yes No  
 Irregular heartbeat (arrhythmia) Yes No  
 Heart pacemaker or defibrillator Yes No  
 Other heart problem Yes No

### GASTROINTESTINAL

Stomach or intestinal ulcers Yes No  
 Gastritis or esophageal reflux Yes No  
 Colitis Yes No  
 Persistent diarrhea Yes No  
 Hepatitis or yellow jaundice Yes No  
 Cirrhosis Yes No  
 Other liver problem Yes No

### GENITO-URINARY

Urinate more than 6 times per day Yes No  
 Kidney or bladder problems Yes No  
 Dialysis Yes No  
 Sexually transmitted disease: Yes No  
 (syphilis, gonorrhea, Chlamydia, herpes)

### HEMATOLOGIC

Blood Transfusion Yes No  
 Anemia Yes No  
 Sickle cell (anemia) disease Yes No  
 Tendency to bleed longer than normal Yes No  
 Hemophilia Yes No  
 Leukemia Yes No

### RESPIRATORY

Hay fever Yes No  
 Sinus trouble Yes No  
 Asthma Yes No  
 Persistent Cough Yes No  
 Bronchitis Yes No  
 Emphysema Yes No  
 Tuberculosis (TB) Yes No  
 Breathing difficulties Yes No

### NEURAL

Stroke or transient ischemia attach Yes No  
 Vision problems Yes No  
 Glaucoma or cataract Yes No  
 Earaches, ringing in ears Yes No  
 Hearing loss Yes No  
 Severe headaches, migraines Yes No  
 Fainting or dizzy spells Yes No  
 Epilepsy, seizures, or convulsions Yes No  
 Nervousness Yes No  
 Psychiatric treatment Yes No

### ENDOCRINE

Diabetes Yes No  
 Thyroid disease Yes No

### DERMAL/ORAL/MUSCULOSKELETAL

Allergy to latex (rubber) Yes No  
 Skin rash or hives Yes No  
 Arthritis, rheumatism or gout Yes No  
 Artificial joint Yes No  
 Fever blisters Yes No  
 Mouth ulcers or canker sores Yes No

### ALLERGIES

Are you allergic to: Yes No  
 Local anesthetics ("novocaine") Yes No  
 Penicillin or other antibiotics Yes No  
 Aspirin Yes No  
 Codeine or other pain medications Yes No  
 Any other drug or medicine (list below)

### OTHER CONDITIONS

Enlarged lymph nodes or "gland" Yes No  
 Persistent or unexplained fevers Yes No  
 Use tobacco Yes No  
 Use alcohol Yes No  
 Drug addiction Yes No  
 Tumor or cancer Yes No  
 X-ray or radiation treatment Yes No  
 HIV-positive/AIDS Yes No  
 Chemotherapy Yes No

\_\_\_\_\_

\_\_\_\_\_

Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind? Yes \_\_\_\_\_  
No \_\_\_\_\_

If yes, what kind and dose?

\_\_\_\_\_

Have you ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe when and why:

\_\_\_\_\_

### **DENTAL HISTORY**

Do you make regular (non-emergency) visits to the dentist?	Yes	No
Do your teeth feel loose?	Yes	No
Do your gums bleed when you brush your teeth?	Yes	No
Are any of your teeth painful to biting or chewing?	Yes	No
Do you ever have pain, or experience clicking, popping or grinding when you open and close your Mouth?	Yes	No
Do you grind or frequently clench your teeth?	Yes	No
Does your mouth frequently feel dry?	Yes	No
Have you ever worn braces or false teeth?	Yes	No
Do you gag easily or do you have a problem with gagging during dental treatment?	Yes	No
Have you ever fainted or had a bad experience related to dental treatment?	Yes	No

Women Only:

Is there a possibility you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No

Do you have any other disease, condition, or problem not listed on this form? If yes, then please explain below:

\_\_\_\_\_

**EMERGENCY CONTACT PHONE NUMBER:** \_\_\_\_\_

**RELATIONSHIP TO CONTACT:** \_\_\_\_\_

To the best of my knowledge, the stated responses are correct and true. If there are any changes in my health history, I will inform the dentist at the next appointment.

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)

\_\_\_\_\_ (relationship to patient, if parent or guardian)