

Welcome

Dr. Kamar Baloul



Adult Health History Form

Today's Date:

Please fill out form in Black Ink.

1. Your Information

Your Name _____
Last First MI

Date of Birth: ____/____/____

Nickname: _____ Male Female

Home # (_____) _____

Cell # (_____) _____

Home Address: _____

City State Zip

Email Address: _____

2. Who may we thank for referring you to our office?

3. Spouse/Partner Information

Name _____ Male Female

Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Hobbies/Sports

5. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City State Zip

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

SS#/ Subscriber ID# _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Dental History

How long since your last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

What is your chief concern? _____

Have you ever had a serious or difficult problem associated with previous dental work? **Yes** **No**

If yes, please explain _____

Have you ever had any pain or tenderness in your jaw/joint? (TMJ/TMD)? **Yes** **No**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

9. Health History

Do you have any of the following conditions?

- | | |
|--|--|
| Y N Are you pregnant? | Y N Do you take Bisphosphate? |
| Y N Abnormal Bleeding | Y N Disabilities/Special Needs |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Disease/Murmur |
| Y N Any Operations | Y N Hemophilia/Blood Disorders |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV + / AIDS |
| Y N Congenital Birth Defects | Y N Kidney/Liver Conditions |
| Y N Convulsions/Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Pregnancy | Y N Allergies to Latex Product |
| Y N Tuberculosis | Y N Diabetes |
| Y N ADD/ADHD | Y N Autism |
| Y N Do you take aspirin? | |

Please discuss any serious medical conditions you have

Please list all drugs you are currently taking _____

Please list all allergies _____

Physicians Name _____

Phone (_____) _____

Are you currently under the care of a physician? **Yes** **No**

Please describe your current physical health...

Good **Fair** **Poor**

10. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Patient _____

Date _____

For Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein.

Initials _____ Date _____

Doctor's Comments _____

Awesome Kids Teeth

Patient Consent form for Unencrypted E-Mail Use

Patient Name/DOB: _____

Patient/Parents/Legal Guardian address: _____

Patient/Parents/Legal Guardian e-mail address: _____

Awesome Kids Teeth offers patients the opportunity to communicate with our organization and Providers by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

- E-mail can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- E-mail senders can misaddress e-mail.
- E-mails are archived, stored and inspected through computer system audits.
- Email can be used to introduce virus into computer systems
- Email can be used as evidence in court

CONDITIONS FOR THE USE OF E-MAIL

We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by our organization. We will not use e-mail communication for matters that may be unlawful or contain PHI or sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, sexually transmitted diseases, and issues of abuse, developmental disability, or substance abuse.

INSTRUCTIONS : To communicate by e-mail, we will request that the patient shall:

- Limit or avoid use of his/her employer's computer.
- Keep the email concise, do not use for sensitive information information regarding STD's substance abuse, mental health or HIV/AIDS)
- Inform us of any changes in his/her e-mail address.
- Include his/her name in the body of the e-mail.
- Include specific category in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear, specific and contains relevant information before sending to our organization.
- Restricted communications from the patient must be provided if applicable.
- Withdraw e-mail consent at any time by e-mail or written communication to our organization or Provider.
- Email will not be used for urgent or emergency situations

PATIENT ACKNOWLEDGMENT AND AGREEMENT EMAIL USE

I acknowledge that I have read and fully understand this e-mail consent form. I understand the risks associated with the communication of e-mail between the organization and my Provider, and consent to the conditions outlined above. In addition, I agree to the instructions outlined as described, as well as any other instructions that the organization may impose to communicate with its patients by e-mail. Any questions I may have had were answered.

Patient/Parents/Legal Guardian Signature: : _____

Date

Witness Signature: _____

Date