

HEALTH HISTORY

Patient Name _____

Birthdate _____

Yes	No	Are you currently under a physician's care? If yes, why? ----- Physician's Name: _____ When was your last complete physical exam?
Yes	No	Have you ever had a serious illness or major surgery? If so, explain
Yes	No	Are you currently taking any prescription medications? List: _____
Yes	No	Do you routinely take health related "over the counter" medications? List: _____
Yes	No	Are you allergic to any medications or substances? What?
Yes	No	Do you have any other allergies? What?
Yes	No	Do you have any problems with penicillin, antibiotics, anesthetics or other meds?
Yes	No	Have you taken any cortisone/ steroid therapy during the past two years?
Yes	No	Are you sensitive to any metals, dyes or latex?
What is the source of your drinking water? <input type="checkbox"/> City <input type="checkbox"/> Well <input type="checkbox"/> Bottled <input type="checkbox"/> Reverse Osmosis		
Women:		
Yes	No	Are you <input type="checkbox"/> pregnant (due date _____) or <input type="checkbox"/> nursing? -----
Yes	No	Are you taking oral contraceptives?

Do you have or have you had any of the following?:

Yes	No	Artificial Joint/prosthesis/implant	Yes	No	Blood Transfusion
Yes	No	Heart Valve Implant	Yes	No	Liver Disease
Yes	No	Mitral Valve Prolapse	Yes	No	Hepatitis A, B, or C
Yes	No	Heart Disease/ Attack	Yes	No	Tuberculosis
Yes	No	Rheumatic Fever	Yes	No	AIDS/HIV Exposure
Yes	No	Heart Murmur	Yes	No	Venereal Disease/Herpes
Yes	No	High/Low Blood Pressure	Yes	No	Alcoholism/Chemical Dependency
Yes	No	Pacemaker	Yes	No	Radiation Therapy
Yes	No	Asthma	Yes	No	Cancer/Tumor
Yes	No	Sinus Problems	Yes	No	Chemotherapy
Yes	No	Epilepsy/seizures	Yes	No	Malignant Hyperthermia
Yes	No	Fainting/Dizzy Spells	Yes	No	Stomach Problems
Yes	No	Psychiatric Treatment	Yes	No	Ulcers
Yes	No	Glaucoma	Yes	No	Nervous Problems
Yes	No	Diabetes/Hypoglycemia	Yes	No	Recent Weight Loss
Yes	No	Eating Disorder	Yes	No	Sleep Apnea/Snoring
Yes	No	Circulatory Problems	Yes	No	Arthritis/Rheumatism
Yes	No	Excessive Bleeding From Cut/Injury	Yes	No	Stroke
Yes	No	Blood Diseases/Anemia/Leukemia	Yes	No	Enzyme Deficiency
Yes	No	Do you smoke or chew tobacco? -----	Daily Intake?		
Yes	No	Interested in quitting?			
Yes	No	Do you have any disease, condition or problem not listed?			

To the best of my knowledge, the above information is true.

Patient Signature _____ Date _____ DDS init. _____

NOTICE OF PRIVACY PRACTICES

FOR YOUR PROTECTION

This notice describes how your personal information may be used and disclosed, and how you can access to this information. Please review this notice carefully.

Woodbury Dental Care has always been committed to maintaining the security and confidentiality of the information we receive from our patients. Whether it's your medical information or identifiable information (such as your name, address, phone number or member identification number), we maintain careful safeguards to protect you against unauthorized access and use.

You should know that we are required by law to provide you this notice about our legal duties and privacy practices. We hope that this notice will clarify our responsibilities to you and provide you with a good understanding of your rights.

PERMITTED HANDLING OF HEALTH INFORMATION

Treatment. This means providing, coordinating, or managing healthcare and related services by one or more treatment providers. An example of this would include teeth cleaning services.

Payment. This means any activity obtaining reimbursement for services, confirming coverage, and billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare Operations. This is the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service. An example of this would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment or other health related services that may interest you.

YOUR AUTHORIZATION

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions regarding your authorization.

YOUR RIGHTS

Woodbury Dental Care would like you to know that beginning on April 14th, 2003; you have the additional rights regarding your personal health information. Your rights are as follows:

- The right to request restrictions on certain uses and disclosures of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

FUTURE CHANGES

Although we follow the privacy practices described in this notice, you should know that under certain circumstances these practices could change in the future. For example, if privacy laws change, we will change our practices to comply with the law. Should this occur:

- We will provide notice to you prior to making significant change in our privacy practices.
- The change will apply to all personal information we have in our possession, including any information created or received before we change the notice.

CONTACT INFORMATION

If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact:

Kyle Edlund DDS
3060B Woodbury Dr.
Woodbury MN 55129

Or

The Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 55125
202-619-0257
877-696-6775

PATIENT REGISTRATION

Patient Name	
Birthdate	Sex M F
Address	
City	Zip
Home Phone	Cell Phone
Work Phone	E Mail
Social Security No.	Marital Status S M
Referred by	

Emergency Contact	Phone
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FOR PATIENTS COVERED BY INSURANCE

Primary Insurance:

Subscriber's Name	
Subscriber's Birthdate	
Subscriber Social Security No.	
Subscriber's Employer	Group No.

Secondary Insurance:

Subscriber's Name	
Subscriber's Birthdate	
Subscriber Social Security No.	
Subscriber's Employer	Group No.

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I understand that I am responsible for payment regardless of insurance coverage, and that finance charges will be applied to balances over 60 days. Credit bureau reports may be obtained.

I have received a copy of the Notice of Privacy Practices, and consent to your uses of my protected health information.

Signature of Patient or Responsible Party _____

Date _____

**MAIL OR FAX THIS FORM TO YOUR PREVIOUS
DENTAL OFFICE**

**PLEASE SEND ALL CURRENT XRAYS FOR THE FOLLOWING
PATIENTS TO:**

**WOODBURY DENTAL CARE
3060 B WOODBURY DRIVE
WOODBURY, MN 55129**

We accept Digital Radiographs to: info@woodburydentalcare.com

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

SIGNATURE OF PATIENT OR GUARDIAN: _____

IF YOU HAVE ANY QUESTIONS PLEASE CALL 651-739-7910

THANK YOU