WOLF RIVER DENTAL
PATIENT MEDICAL HISTORY
(Please Clearly Print All Information)

Patient's Name _____ Sex:___ Female ___Male

Physician's Name (Family M.D.) _____ Date of Birth_____

Have You Ever Had Any of the Following? (Check "Yes" or "No")

YES	NO		YES	NO	
[ ]	[ ]	Mital Valve Prolapse	[ ]	[ ]	Sinus Problems
[ ]	[ ]	Artificial Heart Valve	[ ]	[ ]	Asthma or Emphysema
[ ]	[ ]	Joint Replacement Surgery (Hip, knee, shoulder)	[ ]	[ ]	Cancer, Tumors or Growths
[ ]	[ ]	Heart Attack or Stroke	[ ]	[ ]	Radiation Therapy or Chemotherapy
[ ]	[ ]	Heart Surgery (Including bypass, pacemaker, valves)	[ ]	[ ]	Epilepsy or Seizures
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Athritis / Reumatism
[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	Blood Transusions
[ ]	[ ]	High or Low Blood Pressure	[ ]	[ ]	Kidney Disease
[ ]	[ ]	Diabetes	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Liver Disease, Hepatitis, Jaundice	[ ]	[ ]	Glaucoma
[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Venereal Disease
[ ]	[ ]	Tobacco Use	[ ]	[ ]	Eating Disorder

[ ] [ ] Have you ever tested positive for AIDS or HIV?
[ ] [ ] Do you take medications to control blood pressure, regulate heart rate, or thin blood?
[ ] [ ] Do you have a history of alcoholism or narcotic use?
[ ] [ ] Have you ever had excessive bleeding from a cut or tooth extraction?
[ ] [ ] Females: Are you pregnant at this time? Delivery date:_____
[ ] [ ] Are you being treated by a physician now? For?_____

Please list all operations you have had and reasons for hospitalizations _____

_____

Please check any of the following which you are allergic to, or have reacted adversely to:

[ ] Penicillin [ ] Codeine [ ] Local Anesthetic (Lidocaine, Novocain, etc)
[ ] Erythromycin [ ] Nitrous Oxide [ ] Latex

Please list all medications, foods or other substances not listed above, to which you have an allergy or adverse reaction:

_____

_____

Please list all drugs or medications which you are taking on a regular basis (both prescription and non-prescription, including pain relievers, blood pressure medications, bloods thinners, birth control pills, and vitamin/mineral supplement(s):

_____

_____

Do you have any other medical condition, not listed above, that we should know about? _____

_____

Patient Signature: _____ Today's Date:_____
(Parent or guardian if under 18)

_____

For Office Use Only: History Reviewed

Date:	_____	_____	_____	_____	_____	_____	_____
Patient Initials:	_____	_____	_____	_____	_____	_____	_____
Staff Initials:	_____	_____	_____	_____	_____	_____	_____

Wolf River Dental
HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please print name of Patient Please sign for Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses, step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ____
- I could not communicate with the patient ____
- The patient refused to sign ____
- The patient was unable to sign because ____
- Other (please describe) ____

_____
Signature of Privacy Officer