Patient Health History Form

Complete BOTH sides. Please print.

Name	Date *(month/day/year)* / /

Are you in good health?	**Y**	**N**
Has there been any changes in your medical history in the past 5 years?	**Y**	**N**
Are you under the care of a physician?	**Y**	**N**

Date of last physical exam: (day/month/year)

Physician's Name	Specialist's Name
Address	Address
City/State/Zip	City/State/Zip
Phone	Phone

SECTION 1. Do you have or have you ever had:

CARDIOVASCULAR DISEASE	**Y**	**N**
Congenital, Rheumatic Fever, Congestive Heart Disease?	**Y**	**N**
Heart Murmur, Endocarditis, Pericarditis, Heart Valve Replacement?	**Y**	**N**
Irregular Heart Rate, Arrhythmias, Palpitations, Pacemaker, Atrial Fibrillation?	**Y**	**N**
Chest Pain, Heart Attack, Coronary Artery Disease, Angina?	**Y**	**N**
High or Low Blood Pressure, Stroke, Blockage of Blood Vessels, Blood Clots?	**Y**	**N**
LUNG DISEASE	**Y**	**N**
Asthma, Emphysema, Bronchitis, Shortness of Breath, Tuberculosis, COPD?	**Y**	**N**
Chronic Cough, Severe Coughing, Gag Reflex, Hoarseness, Snoring, Sleep Apnea?	**Y**	**N**
KIDNEY DISEASE	**Y**	**N**
Infection, Stones, Dialysis, Frequent Urination?	**Y**	**N**
DIABETES *Abnormal Blood Sugar?*	**Y**	**N**
LIVER DISEASE	**Y**	**N**
Jaundice, Cirrhosis, Hepatitis A, B, C?	**Y**	**N**
GASTROINTESTINAL DISEASE	**Y**	**N**
Reflux, Ulcers, Colitis?	**Y**	**N**
THYROID DISEASE *Goiter?*	**Y**	**N**
MUSCLE OR BONE DISEASE	**Y**	**N**
Arthritis, Joint Disease, Muscular Dysfunction?	**Y**	**N**
BLOOD DISEASE	**Y**	**N**
Anemia, Sickle Cell Anemia, Bruising, Blood Transfusions?	**Y**	**N**
Uncontrolled Bleeding, Hemophilia, Anticoagulation Therapy?	**Y**	**N**
NEUROLOGICAL DISEASE	**Y**	**N**
Seizures, Dizziness, Convulsions, Epilepsy, Fainting, Numbness?	**Y**	**N**
Psychiatric Treatment, Nervous Disorders or Breakdown, Altered Sensations/Taste?	**Y**	**N**
IMMUNODEFICIENCY	**Y**	**N**
Chemotherapy, HIV AIDS, Organ transplant?	**Y**	**N**
EYE DISEASE	**Y**	**N**
Glaucoma, Dry Eyes, Tearing, Wear Glasses or Contact Lens?	**Y**	**N**
Frequent or Recurrent Lesions or Ulcers of the Mouth?	**Y**	**N**
Radiation (X-Ray) Treatment or Therapy for Cancer or Other Disease?	**Y**	**N**
Sinus or nasal problems, infection, hay fever?	**Y**	**N**
Foreign Objects/Implants: Heart Valves, Blood Vessel, Knee, Hip, Shoulder, Other?	**Y**	**N**
Tumors, Growths, Cysts, Cancers, Chemotherapy?	**Y**	**N**
Popping or clicking of jaw joint, difficulty opening mouth, pain when chewing?	**Y**	**N**
Stomach Ulcers, Gastritis, Reflux, Hiatal Hernia, Colitis, Crohn's Disease, Irritable Bowel Syndrome?	**Y**	**N**
Do you or have you ever used dietary medications (i.e. Phen/Fen)?	**Y**	**N**
Do you or have you used dietary supplements, herbs or additives?	**Y**	**N**
Any disease, drug or transplant operation that could be causing depression of your immune system?	**Y**	**N**
Recurrent or chronic infections of any kind?	**Y**	**N**

SECTION 2. Are you using or taking any of the following:		
• Alcohol?	**Y**	**N**
• Antibiotics (Penicillin, Keflex, Cipro, Erythromycin, Sulfa drugs)?	**Y**	**N**
• Anticoagulants, blood thinners (aspirin, Dipyridamole, Coumadin)?	**Y**	**N**
• Antihistamines, decongestants (Seldane, Tavist-D)?	**Y**	**N**
• Blood pressure medications?	**Y**	**N**
• Osteoporosis medications?	**Y**	**N**
• Heart medications (Digitalis, Inderal, Nitroglycerine, Procardia)?	**Y**	**N**
• Inhalers (Intal, Flonase, Beconase, Ventolin)?	**Y**	**N**
• Recreational drugs (Marijuana, Cocaine, Heroin, Meth, etc.)?	**Y**	**N**
• Steroids (Cortisone)?	**Y**	**N**
• Thyroid Medications (Synthroid)?	**Y**	**N**
• Tobacco? Smoke #____ packs per _____ Dip/Chew #_____ years	**Y**	**N**
SECTION 3. Are you allergic or have you had an adverse reaction to the following?		
• Local anesthesia (Lidocaine, Carbocaine, Marcaine, dental injections)?	**Y**	**N**
• General anesthesia?	**Y**	**N**
• Latex or rubber gloves?	**Y**	**N**
• Antibiotics (Penicillin, Keflex, Cipro, Erythromycin, Sulfa drugs)?	**Y**	**N**
• Other allergies or adverse reactions?	**Y**	**N**
SECTION 4. FOR WOMEN ONLY		
If you are using oral contraceptives, it is important that you understand that antibiotics or other medications my interfere with the effectiveness of birth control. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after competing any course of antibiotics or other medications prescribed for your oral surgery treatment. Please consult your physician for further guidance.		
If you are pregnant, possibly pregnant, or trying to get pregnant, surgery, anesthesia or any other may medications my significantly harm your developing baby, especially in the first trimester.		
• To your knowledge, is there any chance of you being pregnant?	**Y**	**N**
• Do you wish to have a pregnancy test?	**Y**	**N**
SECTION 5. Other medical conditions/concerns		
• Is there any other disease, condition or problem not listed above that you think the doctor should know about?	**Y**	**N**
• Do you wish to talk to the doctor in private about anything?	**Y**	**N**

I understand the importance of an accurate and truthful medical history to assist the doctor in providing the best care possible.

Patient Signature _____ **Assistant Signature** _____

Parent Signature _____ **Doctor Signature** _____

FOR OFFICE USE ONLY

SURGERY	ALLERGIES	MEDICATIONS	DISPENSED

NEW PATIENT REGISTRATION

Welcome to Steele Dental! For scheduling, treatment, and billing purposes, it is important that we have complete and accurate information on file. Please complete this form in its entirety. Thank you.

PATIENT		PRIMARY INSURANCE/ ACCOUNT HOLDER	
		❑ Same as patient *(Please skip to Insurance)*	
Name (Last/ First/ Middle Initial) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss		**Name** (Last/ First/ Middle Initial) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss	
Sex ❑ Male ❑ Female	**Marital status** ❑ S ❑ M ❑ D ❑ W	**Relationship to patient** ❑ Spouse ❑ Parent ❑ Other	
Date of Birth (MM/DD/YY) / /	**Social Security Number** - -	**Date of Birth** (MM/DD/YY) / /	**Social Security Number** - -
Address		**Address**	
City		**City**	
Zip Code		**Zip Code**	
Email address		**Email address**	
Home Phone	**Cell Phone**	**Home Phone**	**Cell Phone**

Who may we thank for referring you to our office? General Dentist:

What is the reason for today's visit?

INSURANCE

Name of Dental Insurance Carrier	**Mailing Address**
Employer	
Subscriber ID	
Group Number	**Phone number**

I certify that the information given above is true and correct to the best of my knowledge. (Copies of insurance cards taken.) I have received a copy of this practice's Notice of Privacy Practices and have been given the opportunity to discuss it. I authorize release of any and all necessary information to my insurance provider for this practice to generate and receive payment directly. I understand that I am financially responsible for the balance on my account regardless of insurance status.

Date **Signature of Responsible Party/Patient**

COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

_____ _____

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? _____
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	If yes, when? _____
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO	

Symptoms – Today, or in the last 14 days:

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste of smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement - By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature Date

FINANCIAL AGREEMENT

Thank you for choosing Steele Dental as your dental care provider. Our greatest concern is your oral health. Anything we do or say will be centered on that philosophy. We are committed to your treatment being successful, and to the return and maintenance of your good oral health. Please understand that payment of your bill is considered part of that treatment. The following is a statement of our Financial Policy, which we ask you read and sign prior to treatment.

Assignment of Benefits

I hereby assign benefits to be paid, on my behalf, to the physician who renders service. I understand and agree to be financially responsible for charges not paid for within 60 days by insurance or other third-party payer and certify that the information given with regard to insurance coverage is correct. **Any remaining balance after insurance pays will be billed to the credit card on file**.

Release of Information

I authorize the physician rendering service to release all or part of my medical records when required for the submission of any insurance claims for payment of services rendered. The physician, his agent and his employees who render service are hereby released from any and all liability of any nature that may arise from the release of such information.

Insurance

If we are a provider for your insurance, the planned procedures may be covered under your policy for a reduced fee. **HOWEVER, IF COVERAGE IS DENIED, THE FEES LISTED ON THE TREATMENT PLAN ARE YOUR RESPONSIBILITY.** A case predetermination may be filed with your insurance carrier to help determine the benefits of your individual policy and obtain an **ESTIMATE** of your portion of the charges due at the time of service. We do not file claims to secondary insurance carriers. Please understand that insurance is a contract between you and your carrier, not our office. **If your insurance carrier has not issued payment within 60 days of service, any unpaid professional fees are due and payable in full from you utilizing the credit card on file.**

Dental Insurance

As a courtesy to our patients with dental insurance, we bill insurance carriers directly. HMO and DMO insurance plans require a specialist referral and pre-authorization prior to service. Co-pays, deductibles, and fees not covered by your insurance carrier are due at the time of service. Any remaining balance after insurance pays will be billed to the credit card on file.

Medical Insurance

Since medical predeterminations are not guarantees of payment, **THE FEES LISTED ON THE TREATMENT PLAN WILL BE REQUIRED PRIOR TO YOUR SURGICAL PROCEDURE**. If your insurance carrier issues payment for your case, the reduced fee will be honored, and any portion of overpayment refunded. **Any remaining balance after insurance pays will be billed to the credit card on file.**

Biopsies

If the specimen is sent for pathologic examination, the pathologist will bill you directly for his services.

Payment Options

We accept cash, check, MasterCard, Discover, Visa and American Express. Payment plans are available.

Financial Policy

- A $50 fee will be assessed for cancelations with less than 24 hour notification.
- A $100 fee will be assessed for unattended scheduled surgery appointments.
- A $25 fee is due for each check payment returned by your bank.
- **When utilizing estimated insurance benefits, a credit card will be required and billed for any remaining balance at the time the insurance payment is received. If your account results in a credit after insurance pays, an immediate credit will be issued to the same card**.
- Any unpaid balance over 60 days will automatically be turned over to collections and a $25 collection fee assessed.
- Any collection fees, court costs, or reasonable attorney fees required to collect unpaid accounts are your responsibility.

The undersigned certifies that she/she has read and understands the foregoing and fully accepts the terms as specified above.

Responsible Party: _____ _____

(Signature) (Date/Time)

_____

(Printed Name)

Authorization to Charge Credit/Debit Card

Steele Dental Specialties

To authorize a one-time or recurring charge to your credit card for treatment services rendered, please complete and sign this form. We adhere to the highest standards for account data protection.

Patient Billing Information

Patient Name: _____

If Patient under 18 years of age, Guardian Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Credit Card Type: ___Visa ___ MC __ Discover __ Amex

Cardholder Name (on credit card): _____

Credit Card #: _____ Exp. _____

Credit Card Security Code: _____

Please initial:

____ One-Time Use – I hereby authorize Steele Dental to charge the above card number for the remaining balance, not covered by insurance. This is a one-time charge authorization. I am not authorizing Steele Dental to set up my account for recurring billing.

Authorization:

I hereby authorize Steele Dental to charge the above card number. I understand all cancellations regarding my account must be in writing. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it for this one-time charge. I understand if this card is declined for any reason, I will be charged a fee of $35.00.

_____ _____

Signature of Cardholder Date

STEELE DENTAL

Authorization for Release of Medical Information

Please note: For your privacy and protection, HIPPA regulations require us to obtain written authorization to share information with your general dentist, other medical provider, or family member regarding your treatment. If you wish to grant this permission, we must have a signed copy of this authorization on file.

Patient Name		**Patient Date of Birth**
Patient Address		
City	**State**	**Zip**

I, the undersigned, authorize **J. Darrell Steele, DDS, MD** to **release** and/or to **obtain** medical and dental information for the above named patient.

Information may be RELEASED to:	**Information may be OBTAINED from:**
Name	**Name**
Phone	**Phone**
Email address	**Email address**

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient or representative **Today's Date**

Name of representative (print) **Relationship to patient**

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: The information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Acknowledgment and Consent of Receipt of Notice of Privacy Practices

J. Darrell Steele, DDS, MD
972.315.3355

All medical facilities are required by Federal and State law to provide each of their patients with a copy of their Notice of Privacy Practices, under the Health Insurance Portability and Accountability Act (HIPAA). This act went into effect April 14, 2003. In addition, we are required by Federal and State law to obtain a signed Acknowledgment from each of our patients indicating they have received the Notice and Consent from our patients to use their health care information for "treatment, payment, and healthcare operations." This act was passed by Congress to protect patients' rights concerning the use of their health care information. In other words, under the new HIPAA regulations, we must take measures to make sure your health care information is not released to parties without your authorization, except for what is necessary to complete our treatment and payment activities. This act will not affect the services you will receive at this office. Thank you for your cooperation.

Purpose of Consent:
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 Acknowledgment and Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Acknowledgment and Consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy policies, 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.

Right to Revoke:
You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we my decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

By my signature below, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of your Notice of Privacy Practices and this Consent form. I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information as necessary to carry out their treatment, payment activities, and health care operations.

INFORMATION SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Name:_____

If this Consent is signed by a parent, guardian, or personal representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient: _____