Anchor Dental
Lafayette Place
2456 Lafayette Road
Portsmouth, NH 03801
Telephone: (603) 436-9908
Fax: (603) 436-1354

___________________________,20__

I,____, authorize
(Name of Patient)

____ to release
(Name of Previous Dentist)

Information related to my health history, status, and treatment, and to transfer copies of my dental records, xrays and any test results to:

Lora Selle, DMD
2456 Lafayette Road
Portsmouth, NH 03801
Email: info@anchordentalnh.com

Thank you,

____

(signature of patient or parent/guardian if a minor)

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.

A SEPARATE PHI DOCUMENT RELEASE MUST BE SIGNED SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

___________________________________ ___________________________________

Please ***print*** your name Please ***sign*** your name

___________________________________ ___________________________________

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ___________________________________

____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes 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

HIPAA made EASY™
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603-436-9908

PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

I was referred by:______________________________________

Name____

Date of Birth_________ Home Phone_____________ Cell Phone______________

Street___________________ City__________________ State______ Zip Code_______

E-Mail____

Social Security #__________________ Payment by: Cash, Check, Credit Card, Insurance

Person Responsible for this bill____________________ Self, Spouse, Parent, Guardian

Address____

Employer___________________ Address____________________ Work Phone_______

Dental Insurance Co.____

Address____

Subscriber's Name____

Subscriber's Address____

Subscriber's Employer name & address_______________________________________

Subscriber's SS#___________________ Subscriber's Date of Birth_________________

Policy #__________________________ Group#_______________________________

SIGNATURE___________________________**DATE**_________________________
This signature authorizes treatment. I understand I am responsible for services rendered to dependent or myself. I also understand that I am responsible for all fees not covered by insurance.

MEDICAL HISTORY

Name of Physician_____________________ Date of last physical__________________

Circle if you have ever had:

Congestive Heart Failure
Congenital Heart Lesion
Cardiac Stents
Heart Bypass Surgery
Heart Attack
Heart Valve Replacement
Defibrillator
Pacemaker
Angina
Irregular Heart Beat
High Blood Pressure
Stroke
Previous Bacterial Endocarditis
Cardiacmyopathy
HIV Positive / AIDS

Alcohol Use: Never Occasionally Daily
Smoke: Never Currently Quit ____years ago
Chew Tobacco: Never Currently Quit ____years ago
Asthma
Lung Disease
Tuberculosis
Hepatitis Type_______
Dialysis
Organ Transplant
Cancer Type_______
Chemotherapy
Radiation Therapy
Artificial Joint Replacement
Diabetes
Seizure disorder
Venereal Disease

Are you allergic to: Penicillin, Codeine, Tetracycline, Local Anesthetic, other ________

Are you allergic to: Latex or Nickel

Have you had any surgical procedures done within the last 6 weeks? Yes No

Have you taken steroids within the last 2 years? Yes No If yes, for how long? Yes No

Are you taking blood thinners? (this includes Aspirin containing drugs) Yes No

Have you EVER taken the drugs Fosamax, Aredia or Zometa?

WOMEN: Are you pregnant? Yes No Are you taking Birth Control Pills? Yes No

PLEASE LIST ANY MEDICATIONS YOU ARE NOW TAKING AND THE REASON

____
____
____
____
____
____
____

DENTAL HISTORY AND QUESTIONNAIRE

Purpose of today's visit____
Are your teeth ever sensitive or painful to you? ____________________
My teeth are sensitive to: Heat Cold Sweet Pressure None
Do you want to save your natural teeth for the rest of your life? ____________
Do you have any fears concerning dentistry? ________________________
What bothers you? ____
Did you like your last dentist? ___________ Reason__________________
When was your last dental cleaning and exam? _____________________
How often do you brush your teeth? _____________________________
Do you use a soft, medium, or hard toothbrush? ____________________
Do you use dental floss? _______________ How often? _____________
Do your gums ever bleed or hurt when you brush and floss? ___________
Have you ever had a gum infection or gum (periodontal) surgery? _________
Are you aware of any swelling or lump in your mouth or neck? __________
Do you often have headaches? ___________________________________
Have you ever had nitrous oxide (laughing gas) in a dental office? _________
Have you ever lost any permanent teeth? ________ Why?_______________
Do you have any dental implants? ________________________________
Do you have any bridges, partial dentures, or full dentures? ____________
Are they comfortable? ____
How do you feel about false teeth? _______________________________
Do you ever grind or clench your teeth? __________Day or night? __________
Do you have pain or popping of your jaw? _________ Right or Left side? _______
Do you chew on both side of your mouth, or do you favor one side? _________
Do you feel your teeth are in good, fair, or poor condition? _______________
Are you pleased with the appearance of your smile? ____________________
Do you prefer composite (tooth colored) or amalgam (silver) restorations for your back teeth? _______________________
Do you participate in any contact sports? __________________________
Do you wear a protective mouth guard when playing sports? ______________

For office use only: Medical history updated
Date___________ Change_____________________________________