Complete Health
DENTISTRY of Brunswick
THE RIGHT WAY FOR THE RIGHT REASONS
VOCAL & TEAM
www.davidvocaldds.com

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you!

COMPLETE HEALTH MEDICAL & DENTAL HISTORY FORM

Patient's name: _____ Nickname: _____ DOB: _____

If minor, Parents/Guardian_____ Home Phone: _____ Cell: _____
E-mail:_____**Would you prefer us to contact you by: ☐ **TEXT** ☐ **EMAIL** ☐ **PHONE CALL (Please check one)**
Mailing address: _____ City _____ State/Zip _____
Employer: _____
Occupation:_____
Emergency Contact Name: _____ **Tel. No.:** _____
To whom may we thank for referring you? _____

Name of **Primary Care Doctor**: _____ Office No: _____
Name of a **specialist** you may be seeing (please list specialty type): _____ Office No:_____

INSURANCE INFORMATION:

☐ Dental Insurance Company _____ Group ID: _____
Subscriber ID No.: _____ Soc. Sec. No: _____
If covered by spouse's/parent's insurance, please provide:
Spouse's/Parents Name: _____ Employer:_____
DOB: _____ SSN: _____ Ph. No.: _____

Personal Medical/Dental History

Do you have or have you had any of the following? (Check all that apply)

- ☐ Cancer or Tumor
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Artificial Joint or Valve
- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Hepatitis or Liver Disease
- ☐ Alcoholism or Drug Abuse
- ☐ Blood transfusion
- ☐ Neurologic Condition
- ☐ Epilepsy or Seizures
- ☐ Herpes or Cold sores
- ☐ Abnormal Bleeding after extractions, surgery, trauma
- ☐ Anemia or Blood Disorders
- ☐ Sleep Apnea – CPAP use
- ☐ Sinus trouble
- ☐ Allergies or Hay Fever or Hives
- ☐ Diabetes – Type I or Type II
- ☐ Anxiety or Depression
- ☐ Fainting or Dizzy Spells
- ☐ PTSD – Post Traumatic Stress Disorder

- ☐ COPD, Lung Trouble or Difficulty Breathing
- ☐ ASTHMA
- ☐ AIDS or HIV Positive
- ☐ Migraines or Frequent Headaches
- ☐ Stroke/TIA or Heart Attack
- ☐ Ulcers
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Acid Reflux, GERD
- ☐ Other:

_____

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex Materials - Reaction _____
- ☐ Penicillin – Reaction _____
- ☐ Amoxicillin – Reaction _____
- ☐ Clindamycin – Reaction _____
- ☐ Other Antibiotic_____

Reaction _____

- ☐ Local Anesthetics ("Novocain") – Reaction _____
- ☐ Sulfites – Reaction _____
- ☐ Aspirin - Reaction - _____
- ☐ Iodine – Reaction _____

- ☐ Barbiturates, sedatives, or sleeping pills Reaction _____
- ☐ Codeine Reaction _____
- ☐ Other Narcotic Reaction_____
- ☐ Sulfa drugs Reaction _____

- ☐ Other: _____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or Sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin (Humalog, Orinase, etc)
- ☐ Nitroglycerine
- ☐ Steroids
- ☐ Osteoporosis (bone density) ie: Fosamax or Boniva
- ☐ Marijuana Use

Women:

- ☐ May be pregnant (due date)
- ☐ Taking hormones or contraceptive

Personal Health

Do you smoke **or** use chewing tobacco **or** e-Cigarettes? ☐ Yes ☐ No
Is there a specific dental problem that you currently have? _____
Would you like to have straighter teeth? ☐ Yes ☐ No
Have you had any surgery since your last visit? ☐ Yes ☐ No
If yes, when and what kind of surgery? _____
Are you required to take a premedication? ☐ YES/NO ☐ Medication: _____
If yes, for how long? _____

*****Please list all prescription and non-prescription medications, vitamins, home remedies and herbs below or provide a copy of medications/supplements******

_____ _____ _____

_____ _____ _____

_____ _____ _____

By initialing, I authorize payment of dental benefits to be sent directly to David Vocal, DDS for services provided. I authorize the release of any information relating to my claims. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I understand that final financial responsibility will be determined when the insurance carrier processes claims. _____ (Initials)

By initialing, I acknowledge the HIPPA Privacy Rule, the 24-hour cancellation policy, and assume financial responsibility for services provided: _____ (Initials)

Patient Signature/Guardian: _____ Date: _____

Ask us about our Complete Health Dental approach!

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DENTISTRY of Brunswick

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Healthy Mouth Baseline

Check all that apply …

- ☐ Oral Cancer
- ☐ Lumps and/or Sores
- ☐ Infection/Abscess
- ☐ Missing/Loose Teeth
- ☐ Crowded Teeth
- ☐ Large Gaps/Spaces
- ☐ Bad Breath/Taste
- ☐ Food Traps
- ☐ Dry Mouth
- ☐ Ice Chewing
- ☐ Frequent Headaches
- ☐ Clenching/Grinding
- ☐ Excessive Tooth Wear
- ☐ Jaw Pain/Clicking/Popping in Joint

- Deep Gum Pocket Depths ☐
- Bleeding/Swollen/Red Gums ☐
- Plaque/Tartar ☐
- Receding Gums ☐
- Gum Disease ☐
- Smoking ☐
- Chronic Fatigue ☐
- Sleep Disorder/Snoring ☐
- Cavities ☐
- Old Fillings ☐
- Acid Reflux ☐
- Discolored Teeth ☐
- Hot/Cold Sensitivity ☐
- Cracked/Broken Teeth ☐
- Biting/Pressure Sensitivity ☐

Do you have any of these?

A Healthy Mouth Protects Your Brain, Heart & General Health

DAVID C. VOCAL, DDS

135 Maine Street, Suite 1
Brunswick, Maine 04011
Tel: (207) 725-5831 Fax: (207) 729-1915

***Note**: Completion of this form is optional. To be valid, this form must be filled out **COMPLETELY**, including what information you are giving us permission to share.

Patient Name: _____**Date of Birth**: _____

I give permission to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

☐ Discuss scheduling/appointment information

☐ Make changes to my scheduled appointments; cancel, reschedule or make appointments

☐ Discuss current and future dental treatment plans, including referrals to specialists

☐ Medical/dental information, including my symptoms, diagnosis, and medications

☐ Billing, insurance and payment information

Dr. David Vocal's office has my permission to discuss the above information with:

Name: _____ **Relationship to Patient**: _____

I understand that I may cancel this permission at any time but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.

☐ **I decline permission to verbally discuss medical/dental information.**

Patient's Signature: _____ **Today's Date**: _____

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Cancellation and Failed Appointment Policy

Your oral hygiene is important to us and we strive to provide excellent dental care to you, as well as all of our patients. In order for us to keep this level of service, we have a Cancellation and Failed Appointment Policy that allows us to schedule appointments for all patients. When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hour's notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

Our policy is as follows:

For regular appointments, we require at least 24 hours notice for any appointment changes or cancellations.

For appointments 90 minutes and longer (such as for crowns, bridges or scaling and root planning), we require at least 48 hours notice for any appointment changes or cancellations.

Three late cancellations or failed appointments (or the combination of) may result in a dismissal from our practice. We understand that situations may arise which prevent proper notification for missing an appointment, so we will review each account for evidence of abuse of the cancellation policy.

This policy allows for other patients to be scheduled into the appointment time you cannot make. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our office know and we will be glad to clarify any questions you have.

We thank you for trusting us with your dental care.

I have read and understand the Cancellation and Failed Appointment Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient ***Date***

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, [patient] understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have read this facility's ***Notice of Privacy Practices*** [on the reverse side of this Agreement] which provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Signature of Patient Witness

Printed Name: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:

a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.
b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.
c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a. To you.
b. As required by federal, state, or law.
c. If child abuse or neglect is suspected.
d. Public health risks for public health activities to prevent and control of disease.
e. Lawsuits and disputes in response to a court or administrative order.
f. Law enforcement to help law enforcement officials respond to criminal activities.
g. Coroners, medical examiners, and funeral directors.
h. Organ and tissue donation facilities if you are an organ donor.
i. To avert a threat to individual or public health or safety.

III. Disclosures where we have to give you a chance to agree or object:

a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b. Persons involved in your care or payment for your care – we may share health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:

1. Right to inspect your health record and to receive a copy of your health record upon request.
2. Right to amend information in your health record you believe is inaccurate or incomplete.
3. Right to know to whom we have disclosed your health information.
4. Right to ask for limits on the health information data we give out about you.
5. Right to receive communication from us about your health information in alternative ways.
6. Right to a paper copy of the complete Notice of Privacy Practices.