MEDICAL UPDATE

***Patient Name*_____________________________ *D/O/B*_________ *Phone#*__________________**
***Policy Holder*_____________________________ *D/O/B*______________**
***Email*____**
***Insurance*______________________________ *Employer*____________________________**
***Member ID/SSN*__________________________________**
***Home Address*_____________________________________**
***City*___________________________ *State*_____________ *Zip*__________________**

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY, HEALTH PROBLEMS THAT YOU MAY HAVE OR MEDICATIONS.

Are you under a physician's care now? YES/NO If yes, why?____________________________
Have you ever been Hospitalized or had a Major Operation? YES/NO If yes__________________
Have you ever had a Serious Head or Neck Injury? YES/NO If yes__________________________
Are you taking any Medications, Pills or Drugs? YES/NO If yes____________________________
Do you take, or have taken, Phen-Fen or Redux? YES/NO If yes____________________________
Have you Taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? YES/NO
If yes____

Are you on a Special Diet? YES/NO Do you use Tobacco? YES/NO
WOMEN: Are You....... __Pregnant/Trying to get Pregnant ___Nursing? ___Taking Oral Contraceptives?
Are You Allergic to Any of the Following?
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Sulfa Drugs ___Local Anesthetics
Other? If yes ____
Do you Use Controlled Substances? YES/NO If Yes____

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

AID/HIV Positive? Y/N	Cortisone Medicine? Y/N	Hemophilia? Y/N	Radiation Treatments? Y/N
Alzheimer's? Y/N	Diabetes? Y/N	Hepatitis A? Y/N	Recent Weight Loss? Y/N
Anaphylaxis? Y/N	Drug Addiction? Y/N	Hepatitis B/C? Y/N	Renal Dialysis? Y/N
Anemia? Y/N	Easily Winded? Y/N	Herpes? Y/N	Rheumatic Fever? Y/N
Angina? Y/N	Emphysema? Y/N	High Blood Pressure? Y/N	Rheumatism? Y/N
Arthritis/Gout? Y/N	Epilepsy/Seizures? Y/N	High Cholesterol? Y/N	Scarlet Fever? Y/N
Artificial Heart Valve? Y/N	Excessive Bleeding? Y/N	Hives or Rash? Y/N	Shingles? Y/N
Artificial Joint? Y/N	Excessive Thirst? Y/N	Hypoglycemia? Y/N	Sickle Cell Disease? Y/N
Asthma? Y/N	ainting Spells? Y/N	Irregular heartbeat? Y/N	Sinus Trouble? Y/N
Blood Disease? Y/N	Frequent Cough? Y/N	Kidney Problems? Y/N	Spina Bifida? Y/N
Blood Transfusion? Y/N	Frequent Diarrhea? Y/N	Leukemia? Y/N	Stomach Disease? Y/N
Breathing Problems? Y/N	Frequent Headaches? Y/N	Liver Disease? Y/N	Stroke? Y/N
Bruise Easily? Y/N	Genital Herpes? Y/N	Low Blood Pressure? Y/N	Swelling of Limbs? Y/N
Cancer? Y/N	Glaucoma? Y/N	Lung Disease? Y/N	Thyroid Disease? Y/N
Chemotherapy? Y/N	Hay Fever? Y/N	Mitral Valve Prolapse? Y/N	Tonsillitis? Y/N
Chest Pains? Y/N	Heart Attack? Y/N	Osteoporosis? Y/N	Tuberculosis? Y/N
Cold Sores/Blisters? Y/N	Heart Murmur? Y/N	Pain in Jaw Joints? Y/N	Tumors/Growths? Y/N
Heart Disorder? Y/N	Heart Pacemaker? Y/N	Parathyroid Disease> Y/N	Ulcers? Y/N
Convulsions? Y/N	Heart Trouble? Y/N	Psychiatric Care? Y/N	Venereal Disease? Y/N
			Yellow Jaundice? Y/N

To the best of my knowledge, the questions on this form have been accurately Answered. I understand that providing incorrect information can be dangerous to my health. It's my Responsibility to inform the dental office of any changes in my medical status. X____ Date _________________

PATIENT CONSENT FORM HIPPA AUTHORIZATION

3138 S.E. Military Drive, Suite 104 San Antonio, TX 78223
(210) 533-1100 office www.citybasedentalcare.com (210) 333-3363 fax

***PATIENT NAME** (please print)**:**____*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and management analysis.*

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices when deemed necessary and that I may contact this organization at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to execute treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that we have taken action relying on this consent.

I have read this form and agree to the uses and disclosures of the information as described.

***Date:** ______________ **Patient Signature:** ____*

If you are signing as a personal representative of the patient, please fill out the information below.

***Date:** __________ **Relationship to Patient:**____*

***Print Name of Representative:** ____*

***Print Name of Patient:** ____*