Tillamook Family Dentistry
Jin Ahn DMD
Welcome to Our Practice

Patient Information:

First Name_____ MI_____ Last Name_____

Preferred Name_____ Date of Birth_____

Driver's License #_____ Social Security #_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Emergency Contact_____ Phone_____

Responsible Party (if different from above):

Name_____ Relationship to pt._____

Date of Birth_____ Social security#_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? Yes No

Dental and Medical History:

Reason for today's visit_____

Former Dentist_____

Date of last Dental Care_____ Date of last x-rays_____

Primary Care Physician_____ Phone_____

Preferred Pharmacy_____

Have you been instructed to pre-medicate with antibiotics prior to dental care? Yes No

Please give a minimum of 24 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge $50.00 for missed appointments or appointments cancelled without 24 hours notice. We will exercise this right at our discretion.

Patient/Responsible Party Signature_____ **Date**_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ 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 ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

POLICIES AND PROCEDURES

Welcome to Tillamook Family Dentistry. We look forward to caring for your dental health and will make every effort to see that you dental experience is as comfortable as possible. For us to better serve our patients there are several policies and procedures that you need to know:

1. Following your new patient exam, Dr. Ahn will make a determination of your dental needs. This requires a general review of your health history, an extensive exam of your teeth and gums, and may include numerous x-rays.
2. Before treatment is undertaken, we consult with our patients so there is a full understanding of the need, the procedures, and possible consequences if necessary treatment is not completed. When requested, you will receive a treatment plan, which includes the estimated cost of the treatment you need. Changes are always possible and will be discussed with you.
3. Please remember that all treatment charges are your responsibility and are charged to you. You will generally be asked to make a payment at the time of service. If you have insurance we will bill them as a courtesy to you; however any portion not covered is your responsibility.
4. We reserve the right to charge $50.00 for appointments cancelled or broken without 24 hours notice.
5. A parent or guardian must accompany a minor child to an appointment. For liability reasons, parents are asked to wait in waiting room. However depending on a child's age, each case will be evaluated if there is a problem.

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes:

1. Treatment: Means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would be a referral to a specialist.
2. Payment: Means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance for payment.
3. Health Care Operations: Includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of the would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. Any other uses will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request, except to the extent that we have already taken action relying on your authorization. You have the following rights with respect to your health information, which you can exercise by a written request:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, or any other person as identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to inspect and copy your protected health information.
3. The right to amend your protected health information.
4. The right to receive an accounting of disclosures of protected health information.
5. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice or our legal duties and privacy practices with respect to protected health information. This notice is effective as of 4/13/2003 and we are required to abide by he terms of the privacy practices currently in effect.

By signing my name to this form, I acknowledge that I understand and accept the above Policies and Procedures.

Signature_____ Date_____