Fairbanks Dental Associates

YEARLY PATIENT INFORMATION UPDATE

FIRST NAME: _____ LAST NAME: _____ NICKNAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

SEX: M F MARITAL STATUS: M S D W **SOC. SEC.** #:_____**DOB**:_____

CELL PHONE:_____ HOME PHONE(landline):_____**E-MAIL**:_____

*IN CASE OF EMERGENCY PLEASE NOTIFY_____RELATIONSHIP TO PATIENT:_____ PHONE:_____

ANY CHANGES TO YOUR DENTAL INSURANCE: YES NO IF YES- DENTAL INSURANCE NAME:_____

SUBSCRIBER'S NAME: _____SUBSCRIBER'S DOB:_____ RELATIONSHIP TO PATIENT:_____

SUBSCRIBER ID/SS#:_____ GROUP/PLAN#_____

Current Tobacco Product use? Y N If yes,what products do/did you use?_____ E-Cigs ? Yes_____No_____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? ***(please place a check mark beside each condition that applies)***

____ Blood disorders	____ Stroke	____ Diabetes	____ Fainting
____ Heart disease	____ Lung disease	____ Epilepsy	____ Arthritis
____ Heart attack	____ Tuberculosis	____ Anemia	____ Seasonal Allergies
____ Heart murmur	____ Asthma	____ Tumor history	____ Pregnant if yes, due date_____
____ Rheumatic fever	____ Liver disease	____ Artificial joints	____ Glaucoma
___ Chest pains (Angina)	____ Hepatitis	____ High blood pressure	____ Herpes Simplex Virus
____ AIDS / HIV+	____ Kidney disease	____ Low blood pressure	____ Human Papilloma Virus
____ Padget's Disease	____ Multiple Myeloma	____ Thyroid Issues	____ Gum Disease, did you receive treatment? ___
____ Systemic Lupus	____ AcidReflux	____ Eating Disorder	____ Osteoporosis
____ Sleep Apnea	____ Cancer	____ Psychiatric treatment	____ Bisphosphonate Drug Use (Osteoporosis Drug)

**** NONE OF THE ABOVE CONDITIONS APPLY TO ME _____

OTHER SYSTEMIC CONDITIONS/ Please explain any checked conditions: _____

MEDICATION ALLERGIES (please check all that apply) No Known Drug Allergies ____ Amoxicillin_____ Aspirin____ Clindamycin____

Codeine____ Erythromycin____ Ibuprofen____ Penicillin____ Other:_____

ARE YOU TAKING ANY DRUGS, MEDICATION, OR PILLS? Y N Please list with reason for each medication

_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N EXPLAIN: _____

RESPONSIBLE PARTY SIGNATURE _____ DATE_____

DOCTOR SIGNATURE _____ DATE _____

HIPAA Policy, Texas SB-300 and Consent

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.

Patient Communications: With this consent I hereby give Fairbanks Dental Associates permission to contact me via US Postal service, e-mail and telephone (home/cell/work and permission to leave a message on voice mail or in person) in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations) such as appointment reminders, insurance items, statements, marketing material and any calls pertaining to my clinical care.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully before signing the Consent.

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

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting our office.

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

I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices, I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.

Signature:_____**Date:**_____