DR. AMANDA M. SHEEHAN

www.oaklandfamilydental.com sheehandds@gmail.com

4626 W. Walton Blvd. • Waterford,, MI 48329 (248)674-0384

Health History Form

Chart#:

FOR OFFICE USE ONLY

Patient Name:

Last First MI

Preferred Name

Title: Mr/Ms/Mrs/etc

Gender: ○ Male ○ Female

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone:

Home Mobile Work Ext

Fax Other

Address:

Address 1

Address 2

City State Zip Code _____-____

Medical Information

Are you now under the care of a physician? ◯ Yes ◯ No

Name of your Physician and Phone Number

____

____

Name and Phone Number of your preferred Pharmacy

____

____

Are you in good health? ◯ Yes ◯ No

Date of last physical exam? ______________

Do you wear contact lenses? ◯ Yes ◯ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No

If yes, what was the illness or operation?

____

____

Has there been any change in your general health within the past year? * ◯ Yes ◯ No

If yes, please explain.

____

____

Are you currently taking any prescription or over-the-counter medicine(s)? * ◯ Yes ◯ No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements.

____

____

Are you required to take an antibitotic medication prior to any dental treatment? * ◯ Yes ◯ No

*Please mark your responses as indicated in the desired fields.

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ◯ Yes ◯ No

If yes, please indicate DATE:

____

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actenol, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's Disease? ◯ Yes ◯ No

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or ◯ Yes ◯ No

If yes, indicate DATE treatment began:

____

mestatic cancer?

Do you use controlled substances?

◯ Yes ◯ No

Do you smoke or chew? (including tobacco, cigars, vape pens, marijuana, etc) ◯ Yes ◯ No

If yes, at what frequency?

___

___

Are you interested in quitting?

◯ Yes ◯ No

Do you drink alcoholic beverages? ◯ Yes ◯ No

If yes, how much do you typically drink in a week?

___

___

Women Only - Are you:

☐ Pregnant?

☐ Taking birth control pills or hormone replacement?

☐ Nursing?

If pregnant, when is your due date? ____________

Please indicate whether you currently HAVE or HAVE HAD any of the following diseases, conditions, or problems. By checking the box you are indicating a YES response, any boxes left unmarked will indicate a NO response.

- [ ] *Pre-Medication
- [ ] Alcohol/Drug Depend.
- [ ] Allergies*
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis or RA
- [ ] Artif. Joints/Valves
- [ ] Asthma
- [ ] Automimmune Disease
- [ ] Bleeding Disorders
- [ ] Blood Transfusions
- [ ] Cancer/Tumors
- [ ] Chemo/Radiotherapy
- [ ] Chest Pain/Angina
- [ ] Chronic Pain
- [ ] Damaged Heart Valves
- [ ] Dental Implants
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Dramatic Weight Loss
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Excessive Urination
- [ ] Freq. Bronchitis
- [ ] Freq. Migraines
- [ ] Gastrointestinal Dis
- [ ] GE Reflux/Heartburn
- [ ] Glaucoma
- [ ] Heart Attack
- [ ] Heart Disease/Defect
- [ ] Heart Murmur
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] History of Snoring
- [ ] HIV/AIDS
- [ ] Infective Carditis
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Malnutrition
- [ ] Mitral Valve Prolaps
- [ ] Neurologic Disorders
- [ ] Night Sweats
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Pers. Swollen Glands
- [ ] Prior Orthodontia
- [ ] Psychiatric Disorder
- [ ] Recurrent Infections
- [ ] Rheumatic Fever
- [ ] Sinus Troubles
- [ ] Sleep Apnea
- [ ] Sleep Disorders
- [ ] STDs/HPV
- [ ] Steroid Therapy
- [ ] Stomach Ulcers
- [ ] Stroke/TIA
- [ ] Systemic Lupus
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] xOther: See Below

Do you have any other disease, condition or problem not listed that you think we should know about?

____

____

Heart Disease/Defects:

Please indicate whether you have or have had any of the following heart conditions or defects:

- [ ] Rheumatic Heart Disease
- [ ] Artificial (prosthetic) heart valve*
- [ ] Previous Infective Carditis*
- [ ] Damaged valves in transplanted heart*
- [ ] Congestive Heart Failure
- [ ] Cardiovascular Disease
- [ ] Congenital Heart Disease (CHD)
- [ ] Unrepaired, cyanotic CHD*
- [ ] Repaired CHD (completely in last 6 months)*
- [ ] Repaired CHD with residual effects*
- [ ] Other Congenital Heart Defects

*Except for the conditions marked with an asterisk, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Sleep apnea signs or symptoms:

A checkbox indicates a yes response.

- [ ] Do you snore?
- [ ] Do you grind your teeth?
- [ ] Do you wake up tired or unrefreshed?
- [ ] Have you been told you choke/gasp for breath while sleeping?
- [ ] Do you have morning headaches?
- [ ] Do you wear a CPAP?

Allergies:

Are you allergic to or have you had a reaction to any of the following:

- [ ] Local Anesthetics
- [ ] Aspirin
- [ ] Penicillin or other antibiotics
- [ ] Barbiturates, sedatives, or sleeping pills
- [ ] Sulfa Drugs
- [ ] Codeine or other narcotics
- [ ] Metals
- [ ] Latex (rubber)
- [ ] Iodine
- [ ] Hay Fever/Seasonal
- [ ] Animals
- [ ] Food
- [ ] Other

If other, please explain.

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Insurance and Financial Policy

I understand that services rendered to me are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to MICHIGAN DENTAL PC and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of my claims.
I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I also understand that should my insurance company send payment to me; I will forward the payment within 48 hours. I agree that if I fail to send payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event the patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to the provider.
I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. A photocopy of this assignment shall be considered effective and valid as the original.

☐ ***YOUR SIGNATURE IS NECESSARY FOR US TO: (1) Process all insurance claims, (2) Ensure payment for services provided, (3) Release medical information to insurance companies needed for the processing of your claims, and (4) Release information to other medical and dental providers, including laboratories, when necessary, for your treatment.**

By checking this box, I acknowledge that I have read and agree to the above statements. This acts as my electronic signature.

Photographic and Video Release

I, hereby authorize MICHIGAN DENTAL PC, to take photographs, radiographs, slides, and/or videos of my face, jaws and teeth. We take photographs and videos to record medical information and to communicate better with our patients.
I understand that the images and recordings will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television, social media forums), and professional publications (dental magazines and journals).
I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.
I hereby agree that MICHIGAN DENTAL PC, will have the irrevocable, worldwide right to make, copy, publish, edit and distribute, show, broadcast, display or otherwise use and make available the Images and Recordings and any works that may be derived from them by any means and in any media now existing or hereafter invented for any educational, research or MICHIGAN DENTAL PC related purpose. including, but not limited to the promotion of MICHIGAN DENTAL PC and to authorize other to do the same. I understand and agree that such use of images and recordings may include the use of my name and other non-confidential biographical information. I acknowledge that MICHIGAN DENTAL PC may choose not to use the images and recordings at this time, but may do so at its own discretion later.
I hereby release MICHIGAN DENTAL PC and its officers, agents, employees and members of its governing boards from any and all claims which I may have at any time for invasion of privacy, defamation or any other claim of any kind arising out of the use of the images and recordings.

**I understand and agree that I will not receive any royalties or other payments in connection with the images and recordings or for granting this release.
By checking yes, I acknowledge that I have read this release and fully understand its contents and agree to be bound thereby. I hereby release any and all claims against MICHIGAN DENTAL PC utilizing this material for education purposes. ***

○ Yes ○ No

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).
(Please enter name and relationship to patient.)

____

____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***By checking this box, I acknowledge that I have read the information above regarding the secured uploading of patient information to the web for MICHIGAN DENTAL PC and grant the above permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Name of person filling out this form: *

___

___

Relationship to patient *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Response Date: ___________