PATIENT HEALTH RECORD

Date _____

Name _____ Spouse's Name _____
(last) (first) (initial)

Address _____ Email address _____

Home Phone _____ Business Phone _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Occupation _____ Social Security No. _____-_____-_____ Single _____ Married _____

Closest relative _____ Phone _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Name and address of physician _____

Have you been under a physician's care during the past 2 years? _____ For _____

Have you been treated in a hospital in the past 2 years? _____ For _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Current medications you are taking daily or frequently, including herbal, ADD/ADHD medications and vitamins _____

_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics Other _____

Have you had or do you now have:

	yes	no		yes	no
ADD/ADHD	☐	☐	Hemophilia	☐	☐
Abnormal blood pressure	☐	☐	Hepatitis A, B, or C	☐	☐
AIDS/HIV	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Immune deficiency	☐	☐
Anemia	☐	☐	Kidney trouble or disease	☐	☐
Arthritis	☐	☐	Liver disease	☐	☐
Artificial heart valves	☐	☐	Mitral valve prolapse	☐	☐
Artificial joints	☐	☐	Organ transplant	☐	☐
Asthma	☐	☐	Pacemaker	☐	☐
Blood transfusion	☐	☐	Pain in jaw joints	☐	☐
Cancer	☐	☐	Polio	☐	☐
Chemotherapy	☐	☐	Prolonged bleeding	☐	☐
Chest pain or Angina	☐	☐	Prolonged cough	☐	☐
Congenital heart lesions	☐	☐	Psychiatric treatment	☐	☐
Cosmetic surgery	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle Cell Anemia	☐	☐
Emphysema	☐	☐	Sinus trouble	☐	☐
Epilepsy/Seisures	☐	☐	Stomach Ulcers	☐	☐
Fainting	☐	☐	Stroke	☐	☐
Glaucoma	☐	☐	Thyroid disease	☐	☐
Heart attack or disease	☐	☐	Tuberculosis	☐	☐
Heart murmur or defect	☐	☐	Venereal disease	☐	☐
Heart surgery	☐	☐	Latex Allergy	☐	☐

Have you any disease, condition, or problem not previously listed?

_____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Has anyone explained to you in detail about periodontal disease and informed you of the risk of tooth loss if disease is untreated? _____

Have you had periodonal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

_____

Do you smoke or use tobacco in any way? _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

_____

Have you ever had an unpleasant dental experience? _____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

_____

Signature _____

William P. Huckin, D.D.S.
6012 Sherry Lane
Dallas, Texas 75225

Patients Name _____ Date of Birth _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Dr. William P. Huckin, D.D.S. is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During health care operation, we may need a second opinion.
- For payment purposes, we may use the services of a billing service.
- Filing of Insurance.

We here at Dr. William P. Huckin, D.D.S. are committed to obeying all Federal, State and Local laws and regulation regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

With my consent, Dr. William P. Huckin, may mail to my home, or other designated location any items that assist in carrying out sending appointment reminder cards and patient statements. Also, Dr. William P. Huckin, may call my home, or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TOP (treatment, payment and healthcare operations).

Signed _____ Date _____

(Patient or Legal Guardian)

William P. Huckin, D.D.S.
6012 Sherry Lane
Dallas, Texas 75225
(214) 361-6120

Release and Consent

I authorize William P. Huckin, D.D.S. or designated staff to perform diagnostic procedures, including examinations, x-rays, study models, photographs, and other appropriate diagnostic aids, as may be necessary for proper dental care.

I authorize William P. Huckin, D.D.S. or designated staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I authorize release of any information concerning my health care, advice and treatment provided by William P. Huckin, D.D.S. to another dentist or physician if needed for consultation, my continued health care, or if requested by me.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand and agree that I am responsible for payment of all dental treatment performed on my behalf, including any portion not covered by my insurance, and I understand that payment is due at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the dentist which are otherwise payable to me.

Patients Signature _____

Date _____