Complete Health
DENTISTRY of Brunswick
THE RIGHT WAY FOR THE RIGHT REASONS
VOCAL & TEAM
www.davidvocaldds.com

Complete Health Medical & Dental History Form

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Name:_____ Date:_____ Date of Birth:_____

Whom may we thank for referring you? _____

Insurance Information

Are you covered by dental insurance? [ ] Yes [ ] No

Subscriber Name:_____ Relation to Patient:_____

Birth Date:_____

Address & phone *(if different from patient)*:_____

Insurance Company & address:_____

Subscriber Employed by:_____ Business Phone:_____

ID# (listed on insurance card):_____

Parent or guardian information: Person responsible for the account is a [ ] Parent [ ] Guardian

Name:_____ [ ] Male [ ] Female [ ] Married [ ] Single [ ] Other:_____

Social Security # :_____ Birth Date:_____

Phone Numbers:

Home:_____ Work:_____ Cell:_____

Home Street Address:_____ State:_____ Zip Code:_____

Employer Name:_____ Occupation:_____

Employer Address:_____ State: _____ Zip Code:_____

I authorize payment of dental benefits to be sent directly to David Vocal DDS for services provided.
I authorize the release of any information relating to my claims. I understand that I am responsible for all costs of dental treatment.

Signature _____ Date: _____

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Name and location of your current physician:_____

Date of your last physical exam:_____ Reason for today's visit:_____

Check (V) if you have had problems with any of the following:

☐ Bad Breath
☐ Grinding teeth
☐ Sensitivity to hot
☐ Bleeding gums
☐ Loose teeth or broken fillings
☐ Sensitivity to sweets
☐ Clicking or popping jaw
☐ Periodontal treatment
☐ Sensitivity when biting
☐ Food collection between teeth
☐ Sensitivity to cold
☐ Sores or growths in your mouth

☐ Medications: Please list all prescription and non-prescription medications, vitamins, home remedies and herbs
☐ or provide copy of medications/supplements.

Medications/Supplements	*Dose (mg per pill, doses per day)*	*Start Date*	*End Date*

Allergies or reactions to medication(s):_____

_____

Have you had any tests run at your Physician's office? If so, what were they and when were they run?

_____

_____

Personal Medical History

Have you ever been hospitalized for illness? [ ] Yes [ ] No
Please indicate whether you have had any of the following medical problems:
Include dates to indicate when the problem occurred.

Oral Health

Date of last dental care and former dentisit:_____

Do dental visits make you nervous? [ ] Yes [ ] No [ ] Other Explanation:_____

Is there a specific dental problem that you currently have? _____

How many times per day do you brush your teeth? _____ What type of toothbrush do you see? _____

Do you floss regularly? [ ] Yes [ ] No How often? _____

How often do you see your dentist? _____ Do you ever have bleeding gums? [ ] Yes [ ] No

Would you be interested in straighter teeth with clear aligner therapy? [ ] Yes [ ] No

Whiter teeth? [ ] Yes [ ] No Reduce snoring? [ ] Yes [ ] No

Does your oral health concern you? [ ] Yes [ ] No If yes, why? _____

Surgical History

Periodontal Disease	☐ _____	Leukemia	☐ _____	Psoriasis	☐ _____
Dental infection	☐ _____	Abnormal platelet count	☐ _____	Sjögren's Syndrome	☐ _____
Root Canal	☐ _____	Stomach Ulcers	☐ _____	Autoimmune disorder	☐ _____
Bleeding gums	☐ _____	Chronic Heartburn	☐ _____	Gout	☐ _____
Heart Disease	☐ _____	Restless legs	☐ _____	Polycystic Ovaries	☐ _____
Stroke	☐ _____	Sleep disorder	☐ _____	Thyroid problems	☐ _____
High Cholesterol	☐ _____	Cancer	☐ _____	Depression	☐ _____
Pre-diabetes	☐ _____	Physical Disability	☐ _____	Suicide attempts	☐ _____
Diabetes	☐ _____	Mental Disability	☐ _____	Anxiety/Panic Attacks	☐ _____
Mini-Stroke or TIA	☐ _____	Heart Arrhythmia	☐ _____	Migraine Headaches	☐ _____
Atrial Fibrillation	☐ _____	Heart Valve Problem	☐ _____	Thin Bones/osteoporosis	☐ _____
Poor blood flow to extremities	☐ _____	Rheumatoid Arthritis	☐ _____	Post-traumatic Stress Syndrome	☐ _____
Aortic Aneurysm	☐ _____	Kidney disease	☐ _____	Blood Clot in Legs	☐ _____
Brain aneurysm	☐ _____	Kidney stones	☐ _____	History Hepatitis	☐ _____
Bleeding/clotting Problems	☐ _____	Gallbladder stones	☐ _____	Alcoholism	☐ _____
Blood transfusion	☐ _____	Pancreatic disease	☐ _____	Drug Use	☐ _____
Anemia	☐ _____	Fatty liver	☐ _____	History of AIDS	☐ _____
High red blood Cell count	☐ _____	Lupus	☐ _____		

Please list all other operations with the dates when they occurred.

_____

_____

Social History

Tobacco use

Cigarettes: [ ] Never [ ] Quit: date you quit smoking _____ [ ] Current smoker (packs per day) _____

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco [ ] e-cigarettes [ ] Marijuana

Number of years you've used this tobacco _____

Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past? [ ] Yes [ ] No

How many times have you tried quitting? _____ What methods have you tried? _____

Are you exposed to second-hand smoke? [ ] Yes [ ]No If yes, for how long? _____

Alcohol use

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many drinks do you consume per week? _____ Alcohol type _____

Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No

Other concerns

Caffeine intake

Coffee _____ cups/day Tea _____ cups/day Sodas per day _____ [ ] Diet [ ] Regular

Chocolate _____ ounces per day (Circle one) [ ] Dark [ ] Light

Do you drink energy drinks or take pills to stay awake? [ ] Yes [ ] No If yes, specify _____

Decaffeinated products? [ ] Yes [ ] No If yes, specify / how much _____

Diet

How do you rate your diet? (Please check one) [ ] Good [ ] Fair [ ] Poor

Do you have any food allergies or food sensitivities? [ ] Yes [ ] No If yes, please explain _____

_____

Are you satisfied with your weight? [ ] Yes [ ] No Do you have any specific weight goals? _____

_____

History for Women

How many times have you been pregnant? _____ How many deliveries? _____ miscarriages? _____

Please list any problems you have experienced with pregnancy or delivery: _____

_____

Hysterectomy? [ ] Yes [ ] No When _____ Ovaries removed? [ ] Yes [ ] No

Do you have any history of gestational diabetes? [ ] Yes [ ] No

High blood pressure or eclampsia with pregnancy? [ ] Yes [ ] No

Family history

Please indicated with a check mark any family members who have had any of the following medical conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's mom	Mom's dad	Dad's mom	Dad's dad
Heart Attack								
Stroke								
Diabetes-Type 2 adult onset								
Aortic aneurysm								
Alzheimer's								
Arthritis								
Asthma								
Autoimmune disorder								
Cancer								
High Cholesterol (hypertension)								
Gum Disease								
Bad teeth								

Signature _____ Date: _____

DAVID C. VOCAL, DDS

84 Maine Street
Brunswick, Maine 04011
Tel: (207) 725-5831 Fax: (207) 729-1915

***Note:** Completion of this form is optional. To be valid, this form must be filled out **COMPLETELY**, including what information you are giving us permission to share.

Patient Name: _____ **Date of Birth:** _____

I give permission to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

☐ Discuss scheduling/appointment information

☐ Make changes to my scheduled appointments; cancel, reschedule or make appointments

☐ Discuss current and future dental treatment plans, including referrals to specialists

☐ Medical/dental information, including my symptoms, diagnosis, and medications

☐ Billing, insurance and payment information

Dr. David Vocal's office has my permission to discuss the above information with:

Name:_____ **Relationship to Patient:** _____

I understand that I may cancel this permission at any time but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.

☐ I decline permission to verbally discuss medical/dental information.

Patient's Signature:_____ **Today's Date:**_____

Witness: _____

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RESERVED APPOINTMENT AGREEMENT

Dear Patient,

An appointment time has been reserved specially for you. This convenient appointment system helps our office run smoothly for both our patients and our team. We schedule an appropriate amount of time for your treatment, and we take pride in staying on schedule, preventing any unnecessary waiting time. We want you to know that we value and honor your time!

When making an appointment, please be sure that your other obligations allow you enough time to arrive promptly for your dental visit. Your cooperation allows us to be on time for your appointment and our other patients. If you know that you will be arriving 5 or more minutes late, please call before you come. This way, if it becomes necessary to reschedule your appointment, you will have avoided a hurried trip to the office and made it possible for us to give that time to a patient who is waiting on our VIP list.

If you find you are unable to keep your scheduled appointment, please call in advance so that we may reschedule you at a more convenient time. There will be no charge if we are notified at least 24 business hours before the scheduled appointment. Should you fail to contact us with less than 24 business hours' notice:

1st Time: We will waive the fee as a courtesy (things happen!)

2nd Time and Thereafter: A minimum charge of **$50.00** per visit for the missed appointment time (relative to the treatment scheduled). If you are a family of 2 or 3 scheduled for the same time and find that one of them is not able to attend, please try to keep the other appointments to avoid multiple charges for each of missed appointments.

Thank you for your cooperation, courtesy, and understanding.

Your Complete Health Dental Team!

Print Name _____

Signature _____ Date _____

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, [patient] understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have read this facility's ***Notice of Privacy Practices*** [on the reverse side of this Agreement] which provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Signature of Patient Witness

Printed Name: _____

Date: _____

DAVID C. VOCAL, DDS
NOTICE OF PRIVACY PRACTICES

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:

   a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.
   b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.
   c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

   a. To you.
   b. As required by federal, state, or law.
   c. If child abuse or neglect is suspected.
   d. Public health risks for public health activities to prevent and control of disease.
   e. Lawsuits and disputes in response to a court or administrative order.
   f. Law enforcement to help law enforcement officials respond to criminal activities.
   g. Coroners, medical examiners, and funeral directors.
   h. Organ and tissue donation facilities if you are an organ donor.
   i. To avert a threat to individual or public health or safety.

III. Disclosures where we have to give you a chance to agree or object:

   a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
   b. Persons involved in your care or payment for your care – we may share health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:

   1. Right to inspect your health record and to receive a copy of your health record upon request.
   2. Right to amend information in your health record you believe is inaccurate or incomplete.
   3. Right to know to whom we have disclosed your health information.
   4. Right to ask for limits on the health information data we give out about you.
   5. Right to receive communication from us about your health information in alternative ways.
   6. Right to a paper copy of the complete Notice of Privacy Practices.