

Last name _____ First _____ MI _____ Preferred name _____
 Sex Male Female Marital Status Single Married Child Other _____
 Birthdate (MM/DD/YYYY) _____ SSN _____ Driver License # _____
 Address _____ City _____ State _____ Zip _____
 Mobile # _____ Work # _____ Email _____
 Employer name _____ Occupation _____
 We TEXT reminders, please let us know if (OPT-OUT)

Emergency Contact _____ Relation to Pt _____ Phone # _____
 Whom may we thank for referring you? Friend _____ Google Facebook
 Magazine Flyer Drove by Other _____

I hereby acknowledge **receipt** of the **Financial and billing policies** given to me by HUYLAMDDS, PLLC (DBA HDental) including calling 48 hours ahead to avoid the No-show/Cancellation fee of \$35.
 Signature: _____ Date: _____
 Patient or Parent/Guardian Signature if minor.

I hereby acknowledge **receipt** of the **Notice of Privacy Practice (HIPAA Acknowledgement)** given to me by HUYLAMDDS, PLLC (DBA HDental). I understand that I may inspect or copy the protected health information described by this authorization. I understand 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 actions have been taken in reliance on an authorization I have signed. I understand that my healthcare 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 redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
 Signature: _____ Date: _____
 Patient or Parent/Guardian Signature if minor.

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to HUYLAMDDS, PLLC (DBA HDental) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
 Insurance Company Name _____ Policy ID # _____ Group # _____
 Primary Policy Holder Name and DOB _____
 I authorize HUYLAMDDS, PLLC (DBA HDental) which includes its Dentist and Dental Staff to the following:

- I authorize the use my electronic signature on all insurance submissions.
- I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges, whether or not paid by insurance.

 The above-named entity may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
 I understand that I can revoke this authorization at any time with a signed written consent except to the extent that the covered entity has already acted in reliance upon the authorization and/or for the purpose of obtaining payment for the covered transactions.
 Signature: _____ Date: _____
 Patient or Parent/Guardian Signature if minor.

Physician's Name _____ Date of last visit _____
 Have you had any serious illnesses or operations? Yes No If yes, describe _____
 Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____
 Presently being treated for any other illnesses? Yes No If yes, give details _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and redux (dexfenfluramine). Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (√) if you take antibiotic pre-medication for your dental visits:

Pre-Med - Amoxicillin Pre-Med - Clindamycin Pre-Med Other _____

Check (√) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDs | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Smoke or previously smoked |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other _____ |

Medications (list medications you are currently taking) _____

Allergies Aspirin Codeine Erythromycin Penicillin Sulfa Latex Other _____

Office use only:

Medical history updates:

Date/Initials _____	Date/Initials _____	Date/Initials _____
Date/Initials _____	Date/Initials _____	Date/Initials _____

Reason for Today's Visit _____

Former Dentist _____ Date of last dental care _____

I routinely see my dentist every 3 mo. 6 mo. 12 mo. Not routinely

Check (√) if you have or have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Had/have braces, orthodontics |
| <input type="checkbox"/> Bleed gums | <input type="checkbox"/> Growths in mouth | <input type="checkbox"/> Loose teeth/broken fillings |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Had any reactions to local anesthetics | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Complications from past dental treatment | <input type="checkbox"/> Had any teeth removed | <input type="checkbox"/> Sensitivity to cold/hot |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Had trouble getting numb | <input type="checkbox"/> Sores or ulcers |

How often do you floss? _____

How often do you brush? _____

What type of toothbrush do you use? Electric Manual

By checking this box, I acknowledge that the above information is correct, and I understand that it is my responsibility to inform the office of any changes in my health as soon as possible. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in completion of this form.