DENTAL AND MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Do you have a specific dental problem? Explain_____ ☐ Yes ☐ No

Do you have dental examination on a routine basis? Last visit date_____ ☐ Yes ☐ No

Do you think you have active decay (cavities) or gum disease? _____ ☐ Yes ☐ No

Do your gums ever bleed? Explain_____ ☐ Yes ☐ No

Do you brush and floss your teeth on a routine basis?_____ ☐ Yes ☐ No

Does food catch between your teeth? Explain_____ ☐ Yes ☐ No

Do you like your smile or the look of your teeth?_____ ☐ Yes ☐ No

If you do not like your smile or the look of your teeth, what kind of improvement you would like to see done so you can like your smile? _____

_____

Do you ever have clicking, popping or discomfort in your jaw joint?_____ ☐ Yes ☐ No

Do you grind or clench your teeth? _____ ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you Chew tobacco? ☐ Yes ☐ No

Have your past experiences in a dental office always been positive? _____ ☐ Yes ☐ No

Do you have or have you ever had any of the following? Please check YES or NO

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Disease/ Surgery*	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	HIV Positive
☐	☐	Heart murmur or defect*	☐	☐	Recent Blood Transfusion	☐	☐	Recent Weight Loss	☐	☐	Genital Herpes
☐	☐	Irregular Heart Beat	☐	☐	Swelling of Limbs	☐	☐	Frequent Diarrhea	☐	☐	Drug Addiction / Alcoholism
☐	☐	Angina/ Chest pain	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Tattoos / Body Piercing
☐	☐	Heart Attack/ Failure	☐	☐	Breathing problem	☐	☐	Excessive Thirst	☐	☐	Sleep Apnea
☐	☐	Congenital Heart Disorder*	☐	☐	Shortness of Breath	☐	☐	Hypoglycemia	☐	☐	Cold Sores
☐	☐	Mirtal Valve Prolapse*	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	Fever Blisters
☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐	Hepatitis A (Infectious)	☐	☐	Herpes
☐	☐	Rheumatic Fever*	☐	☐	Sinus Trouble	☐	☐	Hepatitis B or C	☐	☐	Stroke
☐	☐	Artificial Heart Valve*	☐	☐	Asthma	☐	☐	Protease Inhibitor	☐	☐	Convulsions
☐	☐	Heart Pace Maker*	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐	Epilepsy or Seizures
☐	☐	Pulmonary Shunt*	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Fainting or Dizziness
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Glaucoma
☐	☐	Low Blood Pressure	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Tumors or Growths
☐	☐	Bacterial Endocarditis*	☐	☐	Chemotherapy	☐	☐	Thyroid Disease	☐	☐	Nervousness
☐	☐	Unexplained Fever	☐	☐	Radiation Treatment	☐	☐	Parathyroid Disease	☐	☐	Psychiatric Care
☐	☐	Bruise Easily	☐	☐	Osteoporosis	☐	☐	Arthritis/ Gout	☐	☐	Alzheimer's Disease
☐	☐	Anemia	☐	☐	Bisphosphonates	☐	☐	Rheumatism	☐	☐	Allergies (Medicines)
☐	☐	Coronary Shunt*	☐	☐	Osteonecrosis of the Jaw	☐	☐	Pain in Jaw Joints	☐	☐	Allergies (Pollen, Dust)
☐	☐	Excessive Bleeding	☐	☐	Aredia I.V.- Reclast I.V.	☐	☐	Cortisone Medicine	☐	☐	Hives or Rash
☐	☐	Sickle Cell Disease	☐	☐	Zometa I.V.	☐	☐	Artificial Joint*	☐	☐	Need Premedication?
☐	☐	Hemophilia	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Venereal Diseases	☐	☐	Ever taken fen-phen?
☐	☐	Methemoglobinemia	☐	☐	Stomach/Intestinal Disease	☐	☐	AIDS	☐	☐	Cochlear implants?

Have you had any other illness not checked above? Explain _____ ☐ Yes ☐ No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? Explain _____ ☐ Yes ☐ No

Are you allergic to any medications or substances? Please check box below_____ ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other: _____

Women (Please check): ☐ Pregnant / trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss_____ ☐ Yes ☐ No

Have you ever had any complications following dental treatment? Explain _____ ☐ Yes ☐ No

Have you been admitted to a hospital or had major operation? Explain _____ ☐ Yes ☐ No

Have you ever had a serious injury to your head or neck? Explain _____ ☐ Yes ☐ No

Are you now under the care of a physician? Explain _____ ☐ Yes ☐ No

Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist or the dental office at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian (if patient is minor)

Reviewed by: Moody W. Malek, D.D.S. Signature of Doctor: _____ Date: _____

PATIENT INFORMATION

Patient Name: _____ Date: _____
LAST FIRST MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor

Social Security #: _____ Date of Birth: _____

Address: _____
STREET APT # CITY STATE ZIP

Telephone: _____
HOME WORK CELL EMAIL

Employer Name: _____ Occupation: _____

Address: _____
STREET CITY STATE ZIP

IF FULL TIME STUDENT, SCHOOL NAME: _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ Patient ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

PRIMARY INSURED **IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

Name of Insured: _____
LAST FIRST MI

Address: _____
STREET APT # CITY STATE ZIP

Telephone: _____
HOME WORK CELL EMAIL

_____
BIRTHRATE (MO/DAY/YEAR) SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT

Employer Name: _____

Address: _____
STREET CITY STATE ZIP

Dental Insurance Company Name: _____ Subscriber #: _____ Group #: _____

SECONDARY INSURED

Name of Insured: _____
LAST FIRST MI

Address: _____
STREET APT # CITY STATE ZIP

Telephone: _____
HOME WORK CELL EMAIL

_____
BIRTHRATE (MO/DAY/YEAR) SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT

Employer Name: _____

Address: _____
STREET CITY STATE ZIP

Dental Insurance Company Name: _____ Subscriber #: _____ Group #: _____

Person to contact in case of emergency: Name _____ Telephone # _____

Address_____ City/State/ZIP_____

Authorization and Consent for Services

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand thatI am responsible for all costs of dental treatment. I hereby authorize the Dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. the information on this page and the Dental and Medical Histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____ _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian or responsible party State Driver's License

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

MOODY W. MALEK, D.D.S., F.A.G.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: (831)442-0620

E-mail: moodymalekdds@gmail.com

Address: 631 E. Alvin Dr., Suite J-1

Salinas, CA 93906

MOODY W. MALEK, D.D.S., F.A.G.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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