Pinckney Family Dentistry

William T Stevenson, DDS
Jill Bell, DDS

Health History Questionnaire

Welcome to our Office. Please complete *both* sides of this Dental/Medical history form so that we may provide you with quality dental care. **Please let front desk know if your Dental Insurance has changed.**

Patient Name: _____ Date: _____
Preferred Name:_____ Gender: He / She / They / Other
Address:_____
Telephone _____Your Date of Birth: _____
Has your Dental Insurance changed, if so, please update here: _____
_____
How often do you Brush your teeth? _____How often do you Floss? _____

Please Circle Yes or No if applies to you.

Are any of your teeth sensitive to?

Hot or Cold?	**Yes or No**
Biting or Chewing?	**Yes or No**
Sweets?	**Yes or No**
Do your gums bleed or hurt?	**Yes or No**
Have any mouth odors or bad taste?	**Yes or No**
Have you noticed any loose teeth or change in your bite?	**Yes or No**
Does food get caught in between any of your teeth?	**Yes or No**
If yes, where? _____	

Do you?

Clench or grind your teeth during day or night?	**Yes or No**
Bite your lips or cheeks regularly?	**Yes or No**
Hold foreign objects with your teeth (pencils, pens, chew fingernails)?	**Yes or No**
Mouth breath while awake or asleep?	**Yes or No**
Smoke/chew tobacco or use other tobacco products?	**Yes or No**
Drink Alcohol?	**Yes or No**

Have you ever had:

Orthodontic treatment?	**Yes or No**
Oral Surgery?	**Yes or No**
Periodontal treatment?	**Yes or No**
A bite plate or mouth guard?	**Yes or No**

Have you experienced:

Clicking or popping of the jaw?	**Yes or No**
Pain (joint, ear, side of face)?	**Yes or No**
Difficulty opening or closing?	**Yes or No**
Head, neck or shoulder aches?	**Yes or No**
Are you happy with your teeth's appearance?	**Yes or No**
Do you feel anxious about having dental treatment?	**Yes or No**
If so, what is your biggest concern?	
Have you ever had a negative dental experience?	**Yes or No**
If yes, please describe:	

Have you ever been told to take pre-medication prior to dental treatment? **Yes or No**
If yes, please describe_____Did you take Pre-med today? **Yes or No**

Please complete other side

Pinckney
Family Dentistry

Medical History

Primary Medical Physicians Name: _____ Phone: _____
Have you been hospitalized in the last 5 years? _____
Being treated by your Physician for any illness? _____
Do you have any known Allergies to (**Latex, Penicillin, Local Anesthetic, Codeine, Food Dye**) any?
Yes or No, if YES please list all Allergies here:_____
Women: Are you currently pregnant? **Yes or No** If yes, when is your due date: _____

Please list current medications below or give front desk your list if available:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please CIRCLE if you have experienced any of the following:

Acid Reflux/GERD	Cancer	Heart Attack	Migraines
ADHD	Chest Pain/Angina	Heart Murmur	Neurological Disorders
AIDS/HIV Positive	Chronic Narcotic Use	Heart Surgery	Pacemaker
Anxiety	Diabetes Type 1	Hepatitis A, B, C	Radiation/Chemotherapy
Arthritis	Diabetes Type 2	High Blood Pressure	Sinus Problems
Artificial Heart Valve	Dizziness	High Cholesterol	Sleep Apnea
Asthma (use inhaler)	Emphysema	Hypoglycemic	Stroke
Autism	Epilepsy/Seizures	Jaundice	Thyroid
Autoimmune Disease	Glaucoma	Joint Replacement	Tuberculosis
Blood Disease	Head Injury	Low Blood Pressure	Ulcers

Have you received your COVID-19 Vaccination? ☐ YES ☐ NO Booster? ☐ YES ☐ NO

Do you have or had any disease, condition, or problem not listed above. Please list below.

Patient/Guardian Signature: _____ Date: _____
Relationship to Patient if Patient is not signing _____

Pinckney
Family Dentistry

William T Stevenson, DDS
Jill Bell, DDS

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $75.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee. If a second appointment is missed, you will be charged the full fee for the visit.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $75.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Pinckney Family Dentistry's Appointment Cancellation Policy.

Pinckney
Family Dentistry

William T Stevenson, DDS
Jill Bell, DDS

Notice of Privacy Practices
Patient Acknowledgement

Effective April 14,2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your health information that we have collected and will collect in the future. To comply with once of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition 10 our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. From time to time it may be necessary for us to make disclosures of your health information in connection with your treatment.

For example: We may make a referral or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please circle: **YES** or **NO** that you have read and understand our practice Notice of Privacy Practices.

Consent for Services:

I consent to dental treatment for myself or my dependent(s) as agreed on at the time of treatment. As a condition of treatment, any dental services performed must be paid at the time of service. Patients with dental insurance understand they are responsible for their account. Our office will prepare the insurance forms and bill the insurance company. We will credit any insurance payments to the patients account. However, we cannot render services on the assumptions that our charges will be paid by insurance. Insurance companies can and do deny payments for a variety of reasons.

I have read the above conditions of treatment and payment and agree to their content:

Print Name: _____

Patient Signature (if 18 or older): _____

Guardian/Parent's Signature: _____

Date: _____

Pinckney
Family Dentistry

William T Stevenson, DDS
Jill Bell, DDS

HIPPA Release of information
AUTHORIZATION FORM

I, _____ hereby authorize ***Pinckney Family Dentistry***, to release to _____ **[Insert full name of person/organization]** my personal health information maintained by ***PinckneyFamily Dentistry, information*** relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to ***Pinckney Family Dentistry.*** However, this authorization may not be revoked if ***Pinckney Family Dentistry,*** employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization form.

I further understand that this authorization form is voluntary and that I may refuse to sign this authorization form. My refusal to sign will not affect my eligibility for benefits or payment for or coverage of services.

Name: _____

Signature: _____

Date: _____