HEALTH HISTORY

15 and over

YOUR ANSWERS ARE IMPORTANT. THEY ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you been a patient in the hospital during the past two years? ..... YES NO
2. Have you been under the care of a physician during the past two years? ..... YES NO
3. Name and phone number of your physician(s).

4. Have you taken any medicine or drugs the past two years? ..... YES NO
5. Please list any medications you are presently taking.

6. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex or any drugs or medications? ..... YES NO
7. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
8. Circle any of the following which you have had or have at present.

Heart Failure	Artificial Joint	Diabetes	Anemia
Heart Disease or Attack	Epilepsy or Seizures	Thyroid Disease	Cold Sores
Angina Pectoris	Bruise Easily	Sickle Cell Disease	Nervousness
High Blood Pressure	Alcoholism	Herpes	HIV
Heart Murmur	Stroke	X-ray or Cobalt Treatment	AIDS
Mitral Valve Prolapse	Kidney Trouble	Chemotherapy	Hepatitis A (infectious)
Rheumatic Fever	Ulcers	Arthritis	Hepatitis B (serum)
Congenital Heart Lesions	Emphysema	Rheumatism	Liver Disease/Jaundice
Congestive Heart Failure	Cough	Cortisone Medicine	Blood Transfusion
Scarlet Fever	Tuberculosis (TB)	Glaucoma	Drug Addiction/Use
Artificial Heart Valve	Asthma	Fainting or Dizzy Spells	Hemophilia
Organ Transplant	Hay Fever	Psychiatric Treatment	Venereal Diseases
Heart Pacemaker	Sinus Trouble	Cancer	Immune System Suppression
Heart Surgery	Allergies or Hives		

9. Are you on a special diet? ..... YES NO
10. Do you use tobacco in any form? (Smoke, Chew) ..... YES NO
11. Do you have any disease, condition, or problem not listed? ..... YES NO
12. WOMEN: Are you pregnant now? ..... YES NO
    Are you taking birth control medication? ..... YES NO
13. "In case of emergency, please list the name, address, and phone numbers of a close relative who does not live at your home address." _____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment.

Date	Signature of Dentist	Signature of Patient, Parent, or Guardian
_____	_____	_____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Patient	Dentist
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This comprehensive medical history responds to contemporary advances in physical evaluation and to increasing malpractice claims.

DENTAL HISTORY

1.How long since you have seen a dentist? _____

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

3. Do any of the following cause tooth discomfort?

Hot _____ Cold _____ Sweets _____ Chewing _____

4. How often do you brush your teeth _____ floss _____

	Yes	No
5. Have you had periodontal gum treatment?	___	___
6. Do your gums bleed or feel tender or irritated?	___	___
7. Are you aware of grinding or clenching your teeth?	___	___
8. Do you have headaches, earaches or neck pain?	___	___
9. Do you have loose, tipped or shifting teeth?	___	___
10. Do you have missing teeth?	___	___
11. Do you wear dentures (partials or full)?	___	___
12. Are you unhappy with your dentures?	___	___
13. Would you like to know more about permanent placement?	___	___
14. Are you unhappy with the appearance of your teeth?	___	___
15. Do you have discolored teeth that bother you?	___	___
16. Would you like your smile to look better or different?	___	___
17. Do you have problems with teeth / fillings breaking?	___	___
18. Have you had any bad dental experience in the past?	___	___
19. Have you worn braces on your teeth? (orthodontics)	___	___

20. Name of previous dentist. _____

21. How were you recommended to this office? _____

Please add anything you feel is important.

Sunset Hills Dental Group, LLC

Dental Insurance Information

Patient Information

Name: _____

Date of Birth: _____ Gender: M F

Student Status: FTS PTS

Relationship to Primary Subscriber/Policyholder

Self Spouse Dependent Child Other

Other Dental Coverage? Y N

If Yes, complete Secondary Insurance Information

Relationship to Secondary Subscriber/Policyholder

Self Spouse Dependent Child Other

Primary Subscriber/Policyholder

Name: _____

Address: _____

_____

City: _____

State: _____ Zipcode: _____

Date of Birth: _____ Gender: M F

Employer Name: _____

Soc. Sec. # or ID #: _____

Plan/Group #: _____

Secondary Subscriber/Policyholder

Name: _____

Address: _____

_____

City: _____

State: _____ Zipcode: _____

Date of Birth: _____ Gender: M F

Employer Name: _____

Soc. Sec. # or ID #: _____

Plan/Group #: _____

Payor/Dental Insurance Company

Name: _____

Address: _____

_____

City: _____

State: _____ Zipcode: _____

Payor/Dental Insurance Company

Name: _____

Address: _____

_____

City: _____

State: _____ Zipcode: _____

SUNSET HILLS DENTAL GROUP, LLC

ASSIGNMENT AUTHORIZATION – SIGNATURE AGREEMENT

A. I authorize release of any information relating to all dental treatment.

B. I authorize payment of my insurance benefit directly to Sunset Hills Dental Group, LLC. I understand that I am financially responsible for all charges not covered by this authorization.

C. The doctors are providers for multiple insurance plans as a convenience to their patients. They are not participants in all plans. It is my responsibility to know if they are participating providers for my specific insurance plan. My insurance policy is a contract between my insurance company and me. The doctors are not a party to that contract but as a courtesy they file insurance claims. If my insurance does not pay the claim within 90 days, I agree to be responsible for any charges incurred. It is my responsibility to provide the doctor with all the necessary information to meet my insurance carrier's requirements.

D. If I fail to pay the amount shown to be due on any bill, Sunset Hills Dental Group, LLC may recover from me the amount due plus its cost in collecting it including any collection agency fees, attorney's fee and court costs.

I have read and fully understand the above:

Signature:_____ Date:_____
(If patient is a minor, Responsible party must sign with relationship to patient.)

You will receive a monthly statement until the balance is cleared, regardless of insurance coverage or prior arrangements made.

Sunset Hills Dental Group

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOWYOU 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 are also required to notify you of any breaches of your unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013, 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 the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the various ways that we may use and disclose protected health information. For each category, we will explain such uses and disclosures and present some examples. Not every use or disclosure in a category will be listed. However, our permitted uses and disclosures of information will fall within one of these categories.

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 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.

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 healthinformation to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare,unless you tell us not to 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 of 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. After your death, we may continue to disclose information to individuals who were involved in your care, for example, so they can continue to pay your bills.

Required by Law: We may use or disclose your health information when we are required to do so by law, for example, in response to a court order.

Public Health and Health Oversight: We may use or disclose your health information for public health activities, such as to prevent or control disease, injury, or disability. We may also use or disclose your health information for health oversight activities, including audits, investigations, inspections, and licensure activities.

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 seriousthreat to your health or safety or the health or safety of others.

National Security and Other Specialized Government Functions: 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, protection of the President, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of an 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).

Research Purposes: We may use or disclose your protected health information for research purposes with approval by a privacy board or an Institutional Review Board of a waiver of authorization requirements. Otherwise, disclosures for research purposes will require your written authorization.

Business Associates: We may disclose your protected health information to certain individuals and companies that we contract with (our "business associates") so that they can perform the job we have asked them to do. For example, we may contract with a billing company to assist us with billing insurance companies and third party payors. To protect your protected health information, however, we require a written agreement with our business associates to ensure they will appropriately safeguard your protected health information and meet the same confidentiality standards that we are required to meet.

Your Authorization: In addition to uses and disclosures of your health information described above, 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 uses 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. In particular, we will not use or disclose your health information for marketing communicationsas defined under HIPAA(except face-to face communications or to give you promotional gifts of nominal value) orfor purposes that would be considered selling your protected health information under HIPAA without your written authorization. We will also, generally, not use disclose health information that would be considered psychotherapy notes without your written authorization except in limited circumstances.

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 $0.50 for each page, plus up to $21.36 total at $15 per hour for staff time to 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 6 years ending on the date of your request. 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 generally required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). If, however, your request is that we not tell your health plan about a service you paid for out-of-pocket in full, we must agree to that restriction.

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.

Contact Officer:Barbara Menos

Telephone: 314-842-5000 Fax: 314-842-7199

Address: 11810 Gravois, St. Louis, MO 63127

Sunset Hills Dental Group

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 of Patient If Different From Above)

_____
(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)**

SUNSET HILLS DENTAL GROUP, INC.

11810 GRAVOIS ROAD ST. LOUIS, MO 63127 (314-842-5000) FAX (314-842-71990

PAYMENT POLICIES

USUALLY PAYMENT IS DUE ON THE DAY SERVICES ARE CHARGED

A 5% DISCOUNT WILL BE GIVEN FOR CHARGES TO ACCOUNTS WHICH ARE PAID IN FULL AT THE TIME THE CHARGES ARE GENERATED.

FOR SERVICES OVER $200.00 SPECIFIC FINANCIAL ARRANGEMENTS MUST BE MADE UNLESS THE CHARGES ARE PAID IN FULL ON THE DATE OF SERVICES.

INSURANCE POLICIES

WE WILL ASSIST YOU WHENEVER POSSIBLE, BUT IT IS YOUR RESPONSIBILITY TO KNOW YOUR DENTAL INSURANCE COMPANY'S POLICIES, GUIDELINES, LIMITS AND RESTRICTIONS.

QUESTIONS REGARDING YOUR COVERAGE IN OR OUT OF NETWORK SHOULD BE DIRECTED TO THE INSURANCE COMPANY BECAUSE THOSE DETAILS ARE NOT ALWAYS AVAILABLE TO US.

WE WILL SUBMIT YOUR INSURANCE CLAIM FOR YOU IF YOU SUPPLY US WITH ALL THE NECESSARY CURRENT INFORMATION.

ANY ESTIMATES OF COVERAGE THAT WE PROVIDE ARE BASED ON OUR BEST ESTIMATE OF YOUR INSURANCE BENEFITS, BY REQUESTING OUR DENTAL CARE YOU ARE ACCEPTING RESPONSIBILITY FOR YOUR ENTIRE CHARGES. ANY AMOUNT NOT PAID BY THE INSURANCE COMPANY IS YOUR RESPONSIBILITY.

ALL INQUIRES ON THE STATUS OF PREVIOUSLY SUBMITTED CLAIMS MUST BE DIRECTED TO YOUR INSURANCE COMPANY.