Patient Name:_____ Date: _____

DuHamel Family Dentistry

It is important for us to know your medical, dental and medication history as they can have a direct bearing on any treatment we may render to you. The information you provide will allow us to better meet your medical/dental concerns. Our staff will be happy to assist you in completing these forms as needed.

In your own words, what are your chief dental and medical complaints?

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

Please list all physicians, osteopaths, dentists, physical therapists, chiropractors, hospitals, clinics who have been involved in the problems for which you are seeking treatment.

Physician Name _____ Address_____ Phone_____
Physician Name _____ Address_____ Phone_____
Physician Name _____ Address_____ Phone_____

Medical History

Height: _____ins **Weight** _____lbs. **Neck Size** _____

Do you have: (please √) **Dr. Reviewing Histories:** _____**Signature:** _____

NO	PAST	NOW		NO	PAST	NOW		NO	PAST	NOW	
❑	❑	❑	Allergies	❑	❑	❑	Fibromyalgia	❑	❑	❑	TB/Lung Disease
❑	❑	❑	Asthma	❑	❑	❑	Swollen Hands/Feet	❑	❑	❑	HIV/Aids
❑	❑	❑	Hay Fever	❑	❑	❑	Cold Hands/Feet	❑	❑	❑	Venereal Disease
❑	❑	❑	Sinus Problems	❑	❑	❑	Brittle Nails	❑	❑	❑	Prostate Problem
❑	❑	❑	Frequent Colds	❑	❑	❑	Skin Rash	❑	❑	❑	Painful/Frequent Urination
❑	❑	❑	Chronic Cough	❑	❑	❑	Dry Skin	❑	❑	❑	Impotence
❑	❑	❑	Snoring	❑	❑	❑	Emotional Upsets	❑	❑	❑	Menstrual Cramps (severe)
❑	❑	❑	Sleep Apnea	❑	❑	❑	Nervous Breakdown	❑	❑	❑	Pregnancy
❑	❑	❑	Dry Mouth	❑	❑	❑	Learning Disability	❑	❑	❑	Birth Control
❑	❑	❑	Mouth Breathing	❑	❑	❑	ADHD	❑	❑	❑	Menopausal Problems
❑	❑	❑	Tongue Thrust	❑	❑	❑	Psychological Care	❑	❑	❑	Muscular Dystrophy
❑	❑	❑	Enlarged Tonsils	❑	❑	❑	Memory Loss	❑	❑	❑	Multiple Sclerosis
❑	❑	❑	Swallowing Problems	❑	❑	❑	Depression	❑	❑	❑	Parkinson Disease
❑	❑	❑	Cold Sores	❑	❑	❑	Perfectionist	❑	❑	❑	Hand Tremors
❑	❑	❑	Nose Bleeds	❑	❑	❑	Poor Digestion	❑	❑	❑	Shaking/Twitching
❑	❑	❑	Earaches/Infections	❑	❑	❑	Laxative Use	❑	❑	❑	Seizures/Epilepsy
❑	❑	❑	Hearing Loss	❑	❑	❑	Diarrhea	❑	❑	❑	Cancer
❑	❑	❑	Vision Problems	❑	❑	❑	Constipation	❑	❑	❑	Chemo/Radiation
❑	❑	❑	Glaucoma	❑	❑	❑	Hemorrhoids	❑	❑	❑	Numb Fingers
❑	❑	❑	Tension Headaches	❑	❑	❑	Ulcers/Stomach Problems	❑	❑	❑	Heart Disease
❑	❑	❑	Migraine Headaches	❑	❑	❑	Gastric Reflux	❑	❑	❑	Heart Murmur
❑	❑	❑	Back Ache	❑	❑	❑	Stomach Gas	❑	❑	❑	Pacemaker
❑	❑	❑	Neck Ache	❑	❑	❑	Gall Bladder Problems	❑	❑	❑	Artificial Heart Valve
❑	❑	❑	Arthritis	❑	❑	❑	Heartburn	❑	❑	❑	Arteriosclerosis
❑	❑	❑	Scoliosis	❑	❑	❑	Diabetes	❑	❑	❑	Varicose Veins
❑	❑	❑	Artificial Limb/Joint	❑	❑	❑	Hypothyroidism	❑	❑	❑	High Blood Pressure
❑	❑	❑	Chronic Pain	❑	❑	❑	Hypoglycemia	❑	❑	❑	Anemia/Blood Disorders
❑	❑	❑	Facial Pain	❑	❑	❑	Kidney Disease	❑	❑	❑	Abnormal Bleeding
❑	❑	❑	Muscle Spasm	❑	❑	❑	Liver Disease	❑	❑	❑	CVA/Stroke
❑	❑	❑	Dizziness	❑	❑	❑	Hepatitis	❑	❑	❑	Insomnia
❑	❑	❑	Fatigue	❑	❑	❑	Scarlet Fever	❑	❑	❑	Under/Over Weight
❑	❑	❑	Fainting Spells	❑	❑	❑	Rheumatic Fever	❑	❑	❑	Other _____

Patient Name:_____ Date: _____

DuHamel Family Dentistry

Medications/Supplements

Do you take over the counter/prescription drugs/supplements? ❑Yes ❑No

Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____

Have you ever taken Fen-Phen, Pondimin or Redux? ❑Yes ❑No
Are you allergic to Latex Gloves? ❑Yes ❑No Do you have skin allergies to metal? ❑Yes ❑No
Are you allergic to any medications or have you had an adverse reaction to any? ❑Yes No❑
❑Penicillin ❑Erythromycin ❑Codeine ❑Novocain ❑Aspirin ❑Other _____

Have any family members had the following and what is their relationship to you?

	Relationship		Relationship
❑ Cancer	_____	❑ Heart Attacks	_____
❑ Stroke	_____	❑ Diabetes	_____
❑ Alcoholism	_____	❑ Migraines	_____

Have you had a major illness? ❑Yes No❑
What was it? _____
When _____
How are you now? _____

Have you been hospitalized? ❑Yes No❑
For what reason? _____
When_____

Are there any other health concerns that we should be aware of? _____
Please describe any regular exercise you do:_____

Nutritional Information (Please √)
How often do you consume?

	3xDaily	Daily	3xWkly	3Mth	Never
Caffeine	❑	❑	❑	❑	❑
Fast Foods	❑	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑	❑

Do you have now or have you had an eating disorder? ❑Yes ❑No

HABITS

NO PAST NOW	NO PAST NOW	NO PAST NOW
❑ ❑ ❑ 3+ hrs. TV per day	❑ ❑ ❑ Recreational Drugs	❑ ❑ ❑ Chew on Ice
❑ ❑ ❑ Chew Tobacco	❑ ❑ ❑ Nail Biting	❑ ❑ ❑ Thumb Sucking
❑ ❑ ❑ Cigarettes	❑ ❑ ❑ Chew Lips/Cheeks	

Patient Name:_____ Date: _____

DuHamel Family Dentistry

CMD-TMJ Questionnaire

Do you have: (please ✓)

NO	PAST	NOW	
❑	❑	❑	Discomfort in right jaw joint
❑	❑	❑	Discomfort in left jaw joint
❑	❑	❑	Tired or tense jaw muscles
❑	❑	❑	Excessively warm jaw muscles
❑	❑	❑	Painful teeth
❑	❑	❑	Tic or nervous twitch
❑	❑	❑	Over closed bite
❑	❑	❑	Difficulty in opening mouth wide
❑	❑	❑	Jaw locking open
❑	❑	❑	Jaw locking shut (closed)
❑	❑	❑	Discomfort in opening jaw
❑	❑	❑	Muscle soreness when jaw is open
❑	❑	❑	Grind teeth
❑	❑	❑	Jaw swings to side when opening

NO	PAST	NOW	
❑	❑	❑	Frequent headaches, neck aches
❑	❑	❑	Clench teeth
❑	❑	❑	Facial muscle soreness in morning
❑	❑	❑	Bite cheeks, lips, tongue while eating
❑	❑	❑	Teeth sensitive to temperature changes
❑	❑	❑	Loose or drifting teeth
❑	❑	❑	Swelling in gums
❑	❑	❑	Orthodontic Treatment
❑	❑	❑	Periodontal Treatment
❑	❑	❑	Salty Taste
❑	❑	❑	Copper or metal taste
❑	❑	❑	Changes in salivation
❑	❑	❑	Tearing for no reason
❑	❑	❑	Pressure behind eyes

Do you have frequent pain in the head and/or neck? ❑Yes ❑No

What area of the head? _____ **When did head/neck pain begin? _____**

How often does pain occur? _____ **How long does pain last? _____**

Please describe any positioning of the jaw that helps to relieve pain. _____

Have you been in an auto accident? ❑Yes ❑No
When? _____
Describe: _____

Have you had any injury to the head/face? ❑Yes ❑No
When? _____
Describe: _____

Please indicate anything else about yourself that you suspect may be related to your condition?

_____

Describe any emotional problems you have regarding your teeth. _____

_____

Do any of the following daily activities cause you any pain or discomfort?

❑ Yawning
❑ Swallowing
❑ Speaking
❑ Singing
❑ Shouting
❑ Brushing Teeth
❑ Turning neck
❑ Turning head
❑ Turning trunk
❑ Turning arms
❑ Moving shoulder

Indicate pain types you experience

❑ Sharp ❑ Deep ❑ Diffused ❑ Cyclic
❑ Dull ❑ Superficial ❑ Constant
❑ Aching ❑ Throbbing ❑Intermittent

What is the intensity of your pain? _____
(1 = no pain, 5 = worse pain)

_____

Do you ever notice any of the following in either of your ears or in the jaw joint?

L	R		L	R		L	R		L	R	
❑	❑	Hearing Loss	❑	❑	Hearing sensitivity	❑	❑	Ringing	❑	❑	Other:
❑	❑	Itching feeling	❑	❑	Ear Infections	❑	❑	Tubes in ears			_____
❑	❑	Popping Noises	❑	❑	Grating	❑	❑	Stuffiness			

Patient Name:_____ Date: _____

DuHamel Family Dentistry

Dental History

Current Dentist_____ Phone_____

Address_____ City_____ Zip_____

Date of last dental visit _____
Date of last Full Mouth X-rays_____
Date of last hygiene (preventive) appointment_____

Do we have your permission (release) to request records? Yes ❑ No ❑

_____
Patient signature:

Please √

NO	PAST	YES	
❑	❑	❑	Are you afraid of dental treatment? Reason _____
❑	❑	❑	Do you have bad breath problems?
❑	❑	❑	Are you unhappy with the appearance of your teeth? Reason _____
❑	❑	❑	Are you fearful of loosing your natural teeth in your lifetime?
❑	❑	❑	Do you have difficulty chewing on both sides of your mouth?
❑	❑	❑	Have you been unhappy with your previous dental treatment? Reason _____

Do you brush your teeth daily? ❑Yes ❑No
How often do you brush? _____
Do you floss? ❑Yes ❑No
How often do you floss? _____

CONSENT FOR TREATMENT

I hereby state that the medical and dental histories are correct to the best of my knowledge.
I authorize routine medical diagnostic procedures to include necessary x-rays. I understand a photograph will be taken as a part of my dental records.

I agree to the use of anesthetics and medications considered necessary by DuHamel Family Dentistry or supervised staff.

Signature_____ Date_____
(Parent signature if patient is a minor)

DuHamel Family Dentistry

Patient Name: _____/_____/_____

Preferred Name:_____ ☐ Male ☐Female

Age: _____ Date of Birth: _____/_____/_____ SS#: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Physical Address (if different): _____

City _____ State _____ Zip Code _____

Preferred Method of Confirmation:

Home Phone # _____ ☐

Work Phone # _____ ☐

Cell # _____ ☐

Email Address _____ ☐

Spouse Information: Name: _____ DOB: _____

How were you referred to our office? ☐Physician ☐Sleep Specialist ☐Dentist ☐Friend ☐Website ☐Radio ☐TV ☐Newspaper ☐Other _____

Dental Insurance Information: Primary

Insured: ☐Self ☐ Spouse ☐Father ☐Mother ☐ Other: _____

Name: _____Date of Birth: _____/_____/_____

Employer: _____SS#: _____

Insurance Company: _____Ph#: _____

ID#: _____ Group #: _____

Dental Insurance Information: Secondary

Insured: ☐Self ☐ Spouse ☐Father ☐Mother ☐ Other: _____

Name: _____Date of Birth: _____/_____/_____

Address (if different): _____

Employer: _____SS#: _____

Insurance Company: _____Ph#: _____

ID#: _____ Group #: _____

Physician:

Name of Primary Care Physician: _____

Phone: _____ Address: _____

City _____ State _____ Zip Code _____

DuHamel Family Dentistry
13 Main Street, P.O. Box 187 Valley Springs, CA 95252
(209) 772-9649 Fax (209) 772-2415
info@duhameldentistry.com

FINANCIAL POLICY

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED**:** We will accept cash, personal check, Visa/MasterCard or American Express. Care Credit is available for those who desire a payment plan. Applications for Care Credit are available at the front desk. **We expect payment on the date of service.**

To keep the cost of dentistry as low as possible, appointments are scheduled to best fit the patient's and the doctor's time**. 2 business days notice** is required to break or reschedule an appointment. **There will be a charge of up to half of the appointment value and no less than a minimum of $60 for any missed or rescheduled appointment with less than 2 business days notice.**

FOR OUR INSURANCE PATIENTS: **All insurance co-pays and deductibles are due at the time of treatment.** As a courtesy to our patients, we submit billing to most insurance companies. However, we can make no guarantee of coverage. **I understand and acknowledge that I am fully and completely responsible for the payment of all cost associated with the services, treatments, procedures and or diagnostic methods preformed and utilized by this office.** Our office will do everything possible to see that you receive the full benefits of your policy. If insurance has not paid within **45** days from the date of service, the balance will be automatically due and payable. It is the responsibility of patients to know their insurance benefits. DuHamel Family Dentistry accepts no responsibility for benefits denied by insurance companies**.** To assist our patients, our treatment plans include an estimated insurance benefit. These are estimates only and should not be considered a guarantee of insurance payment. It is the patient's responsibility to provide this office with ACCURATE insurance information.

Our practice is committed to providing the best treatment for our patients. Please be aware some of the services provided may be non-covered services or not considered reasonable and necessary under individual insurance policies. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Additional charges that may apply: 22% interest on balances over 60 days, $89 charge for collection services, $25 charge for returned check.**

AUTHORIZATION FOR SIGNATURE ON FILE: I hereby authorize the office of DuHamel Family Dentistry to release any and all information, medical/dental (SS#, etc.) as necessary for reimbursement of services from insurance companies and/or for the purpose of referral to a specialist for additional treatment. I understand that I can deny the transmission of such information. I further understand that should I deny permission for the transmission of information, DuHamel Family Dentistry is not responsible for submitting insurance billings on my behalf.

I have been offered or have received the following: NOTICE OF PRIVACY PRACTICES, CONSENT FOR USE AND DISCLOSE OF HEALTH INFORMATION, DENTAL BOARD OF CALIFORNIA FACT SHEET ON DENTAL MATERIALS. All of which are mandated by HIPAA. I have read, understand and agree to the terms and conditions of this document.

We reserve the right to refuse service/treatment according to the laws of the State of California.

_____ _____ _____

Printed Name (Patient) Signature of Patient or Guardian Date

DuHamel
Family Dentistry
13 Main Street, P O Box 187 Valley Springs, CA 95252
(209) 772-9649

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 (11-01-2013), 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 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 providers providing treatment.

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

Health Operations: We may use or 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, evaluation 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 of 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 information to a family member, friend or other person extent necessary to help with your healthcare or with payment for 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 location) 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 requited for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions 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 $1.00 for each page, $45 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 request.
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 (email), 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 location, 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: Kim DuHamel, Office Manager
Telephone: 209-772-9649 Fax: 209-772-2415
Address: P.O. Box 187
Valley Springs, CA 95252

DuHamel Family Dentistry
13 Main Street, P.O. Box 187
Valley Springs, CA 95252
(209) 772-9649

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____ _____
Please Print Name Signature of Patient / Guardian

_____
Date

Would you like us to discuss (or be able to discuss) your treatment and/or your account information?
If so please list names here:_____

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 obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____