CRAIG PEARCE D.M.D.

We are a health centered practice; thus we are concerned with your total well being, not just your oral health. An essential part of our approach is through health history. Please fill out the health questionaire below completely, even if some of the questions may not seem relevant to your dental health.

Patient Name ____ **Birthday** ________/________/_________

Physician Name & Phone Number____ **Last Physical Exam** __________________

Are you receiving any healthcare now? YES____ NO____ **For what purpose?** ____

Are you taking ANY medications? YES____ NO____ **For what purpose?** ____

Please list ALL medication:

____

____

HAVE YOU HAD OR DO YOU HAVE:

ALLERGIES:

Penicillin YES____ NO____

Codeine YES____ NO____

Local Anesthetic YES____ NO____

Latex YES____ NO____

OTHER-

____

____

Any other medical conditions we should know about:

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AIDS YES____ NO____

Anemia YES____ NO____

Asthma YES____ NO____

Blood Transfusion YES____ NO____

Chemo Therapy YES____ NO____

Diabetes YES____ NO____

Drug/Alcohol Dependency YES____ NO____

Epilepsy YES____ NO____

Glaucoma YES____ NO____

Hearing Impaired YES____ NO____

Hip/Joint Replacement YES____ NO____

Hepatitis A, B or C YES____ NO____

Kidney Dialysis YES____ NO____

MRSA YES____ NO____

Oral Herpes YES____ NO____

Prolonged Bleeding YES____ NO____

Pacemaker YES____ NO____

Rheumatic Fever YES____ NO____

Serious Accident YES____ NO____

Sinus Problems YES____ NO____

Heart Conditions:

Abnormal Blood Pressure YES____ NO____

Artificial Valve YES____ NO____

Heart Attack YES____ NO____

Heart Murmur YES____ NO____

Stroke YES____ NO____

Mitral Valve Prolapse YES____ NO____

WOMEN:

Are you pregnant? YES____ NO____

CONSENT FOR TREATMENT: I hereby grant Dr. Craig Pearce and/or his staff in charge of the patient whose name appears on this health history update, to administer any treatment and such X-rays, Anesthetics, and/or Nitrous Oxide Sedation, and to perform such operations as may be deemed necessary or advisable in the treatment of this patient.

SIGNED-__________________________________ **Relationship to Patient-**_________________________ **DATE-**____/____/_____

HIPAA Compliance Patient Consent Form

We keep a record of the health services we provide you. Your personal health information will not be disclosed to anyone without your written consent, including your family. You may give written consent below. We will utilize the information you give us only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington.

Our **NOTICE OF PRIVACY PRACTICES** describes in more detail how your health information may be used and disclosed, as well as how to access your information. If you would like a copy of the statement of privacy policies, you may ask for a copy.

Additional Disclosure Authority

I hereby authorize disclosure of my protected health care information to the person(s) indicated below. This includes information such as my account balances, treatment received, insurance information or scheduled appointments:

Please check one box: None_______ See names listed below________

Name: ____Relationship: _____________________

Name: ____Relationship: _____________________

Name: ____Relationship: _____________________

Name: ____Relationship: _____________________

Name: ____Relationship: _____________________

Signature of Patient or Guardian: ____

Print Name: ____________________________________ **Date:** ____________________________