

**HEALTH HISTORY FORM** v12.02.01a **DR. LISA W. ARNHART, DDS, PC**

-----**PATIENT INFORMATION**-----

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ SEX: M F  
BIRTH DATE \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ MARITAL STATUS: S M W D  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_  
CELL \_\_\_\_\_ OTHER \_\_\_\_\_ **REFERRED BY** \_\_\_\_\_

YOUR PREFERRED NAME / NICK NAME : \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

-----**RESPONSIBLE PARTY / INSURANCE HOLDER INFORMATION**-----

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ SEX: M F  
BIRTH DATE \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ MARITAL STATUS: S M W D  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_  
CELL \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_  
NUMBER OF YEARS EMPLOYED: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**SPOUSE INFORMATION:** NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ BIRTH DATE \_\_\_/\_\_\_/\_\_\_  
WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

-----**EMERGENCY CONTACT**-----

RELATIVE NOT LIVING WITH YOU \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

-----**DENTAL INSURANCE INFORMATION**-----

INS. CO. NAME \_\_\_\_\_ INS CO. PHONE \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_ ZIP \_\_\_\_\_ GROUP # \_\_\_\_\_ HOLDER'S NAME \_\_\_\_\_  
**SECONDARY INS. CO. NAME** \_\_\_\_\_ INS. CO. PHONE \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ GROUP # \_\_\_\_\_ HOLDER'S NAME \_\_\_\_\_

**-----DENTAL HISTORY-----**

NAME OF PREVIOUS DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? \_\_\_\_\_ DATE OF LAST X-RAYS \_\_\_\_\_

REASON FOR YOUR DENTAL VISIT TODAY \_\_\_\_\_

HAVE YOU HAD ANY PERIODONTAL (GUM) PROBLEMS?	[ ] YES [ ] NO	DO YOU FLOSS REGULARLY?	[ ] YES [ ] NO
DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER?	[ ] YES [ ] NO	HAVE YOU WORN BRACES ON YOUR TEETH?	[ ] YES [ ] NO
DO YOU HAVE HEADACHES, EARACHES, OR NECK PAIN?	[ ] YES [ ] NO	ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?	[ ] YES [ ] NO
ARE YOUR TEETH SENSITIVE TO ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY.)	[ ] HOT [ ] COLD [ ] SWEETS [ ] PRESSURE	IF NOT, PLEASE EXPLAIN: _____	

**-----MEDICAL HISTORY-----**

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ARE YOU UNDER A PHYSICIAN'S CARE? [ ] YES [ ] NO IF SO, FOR WHAT? \_\_\_\_\_

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? \_\_\_\_\_

HAVE YOU TAKEN FOSAMAX, BONIVA, ZOMETA OR OTHER MEDICINE TO INCREASE BONE DENSITY? [ ] YES [ ] NO

HAVE YOU EVER TAKEN FEN-PHEN / REDUX? [ ] YES [ ] NO

DO YOU USE ANY TYPE OF TOBACCO PRODUCTS? [ ] YES [ ] NO IF SO, WHAT? \_\_\_\_\_

FOR WOMEN ONLY: ARE YOU PREGNANT? [ ] YES [ ] NO ARE YOU NURSING? \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED? [ ] YES [ ] NO IF SO, FOR WHAT? \_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

- |                            |                         |                           |                          |
|----------------------------|-------------------------|---------------------------|--------------------------|
| [ ] ALCOHOL / DRUG ABUSE   | [ ] EMPHYSEMA           | [ ] HIV / AIDS POSITIVE   | [ ] RESPIRATORY PROBLEMS |
| [ ] ALLERGIES / ASTHMA     | [ ] EPILEPSY            | [ ] KIDNEY DISEASE        | [ ] SEIZURES             |
| [ ] ARTHRITIS              | [ ] EXCESSIVE BLEEDING  | [ ] LIVER DISEASE         | [ ] SINUS PROBLEMS       |
| [ ] ARTIFICIAL HEART VALVE | [ ] FAINTING            | [ ] MITRAL VALVE PROLAPSE | [ ] STOMACH PROBLEMS     |
| [ ] ARTIFICIAL JOINTS      | [ ] GLAUCOMA            | [ ] NERVOUS DISORDER      | [ ] STROKE               |
| [ ] BLOOD DISORDER         | [ ] HEAD INJURIES       | [ ] OSTEOPOROSIS          | [ ] THYROID PROBLEMS     |
| [ ] BLOOD TRANSFUSION      | [ ] HEART ATTACK        | [ ] PACEMAKER             | [ ] TUBERCULOSIS         |
| [ ] CANCER                 | [ ] HEART MURMUR        | [ ] PAIN IN JAW JOINTS    | [ ] TUMORS               |
| [ ] CHEMOTHERAPY           | [ ] HEART PROBLEMS      | [ ] PSYCHIATRIC CARE      | [ ] ULCERS               |
| [ ] DIABETES               | [ ] HEPATITIS           | [ ] RADIATION TREATMENT   | [ ] VENEREAL DISEASE     |
| [ ] DIZZINESS              | [ ] HIGH BLOOD PRESSURE | OTHER _____               |                          |

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING:

- |             |                      |                  |                  |
|-------------|----------------------|------------------|------------------|
| [ ] LATEX   | [ ] LOCAL ANESTHETIC | [ ] ERYTHROMYCIN | [ ] TETRACYCLINE |
| [ ] CODEINE | [ ] PENICILLIN       | [ ] IBUPROFEN    | [ ] OTHER _____  |

**-----CONSENT-----**

THE UNDERSIGNED HEREBY AUTHORIZES DR ARNHART TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR ARNHART TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DR ARNHART TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION, AND THERAPY THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN MY INSURANCE CARRIER AND MYSELF, NOT BETWEEN MY INSURANCE CARRIER AND DR ARNHART. I AM SOLELY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO DR ARNHART. ANY PAYMENTS RECEIVED BY DR ARNHART FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT. I FURTHER UNDERSTAND THAT A LATE CHARGE OR FINANCE CHARGE MAY BE ADDED TO ANY OVERDUE OR OUTSTANDING BALANCE. I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED AND MISSED APPOINTMENT FEES MAY BE CHARGED.

PATIENT / RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Lisa W. Arnhart, DDS PC

# 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.

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**Please Print Name**

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**Signature**

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**Date**

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**For Office Use Only**

We attempted to obtain written acknowledgment 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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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

**In order for Dr. Arnhart's office to file a claim to your insurance company, please the following guidelines carefully:**

In an effort to address our patients' insurance concerns, we've put together the following guidelines based on questions we have been asked most frequently in the past. If you require additional information please ask a staff member for assistance:

**Know Your Insurance Coverage:**

This is the single most important thing you can do to ensure your visit is covered by your insurance company. Knowing your co-pays, primary care provider, whether or not your deductible has been met for the year, what your material allowables are, and if Dr. Arnhart is a contracted network provider for your insurance company are just a few of these critical items. Please understand that it is impossible for us to know exactly what your benefits are.

**Once Dr. Arnhart's office submits a claim for me, what happens next?**

If all goes well we receive a payment from your insurance company in 30-60 days. However, if your claim hasn't been paid in 60 days, our billing department may contact you for help in solving the problem by sending a statement showing balance on unpaid claims.

**If my insurance company doesn't pay my claim in 60 days, how can I help?**

You can help Dr. Arnhart's office by calling your insurance company and asking why your bill hasn't been paid. Claims representatives document every inquiry received and they don't like hearing from unhappy subscribers. We will have already called them and or submitted duplicate claims; therefore they should be aware of the problem. Hearing from you forces them to review the claim yet another time.

**If my insurance company refuses to pay because I forgot to tell them I was being seen at Dr. Arnhart's office or my policy has changed in some way thus limiting the services I'm entitled to, is it my responsibility to pay the bill?**

Yes. We ask that you settle your account with us, but also advise you to continue to pursue the payment from your insurance company. Our experience has been that insurance companies will pay your bills if you can prove they promised you benefits you did not receive.

**Why wouldn't my insurance cover my care in full? I pay a premium each month that should cover any services I might receive.**

If insurance is rejecting your claim it could be, but is not limited to: is a deductible that needs to be met, incorrect patient information (i.e. social security no., ID number) or the procedure may not be covered under your policy. We obtain your information from you and the insurance card that you present at the time of your visit. It is imperative that you have a current card and that all information is verified at the time of check in.

Our commitment is to your dental health care, not your insurance company's bottom line. We need your support in this partnership. Together, we will be successful in providing you top quality dental care to meet all your dental health needs.

# NOTICE OF PRIVACY PRACTICES

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**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.**

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## **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.

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## **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).

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## 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, \$10.00 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.

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## 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: Lisa W. Arnhart, D.D.S., P.C.

Telephone: (505) 897-6453

Fax: (505) 897-8027

E-mail: \_\_\_\_\_

Address: 8521 Golf Course NW, Suite 116 Albuquerque, NM 87114

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