432-366-1486

LAST NAME | FIRST NAME | AGE | NAME OF PHYSICIAN

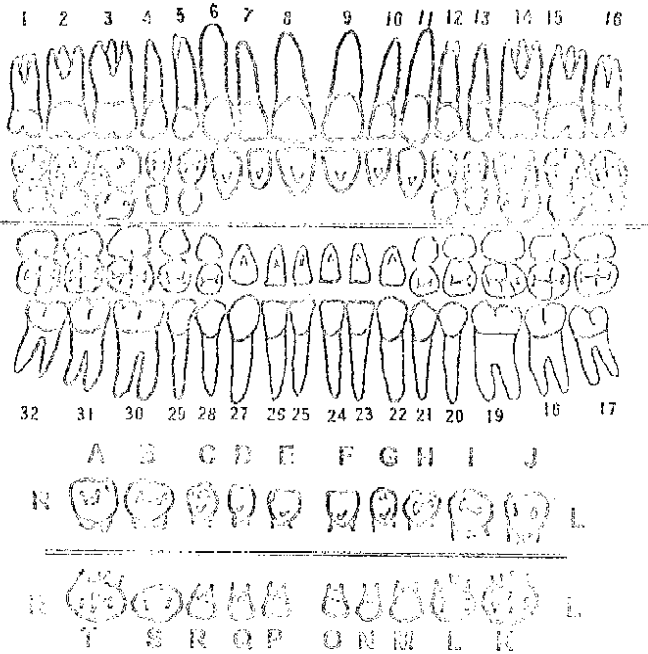
ADDRESS | HOME TELEPHONE | WORK TELEPHONE

CITY | ZIP | SPOUSE OR CLOSEST RELATIVE

DATE OF EXAM.

X-RAYS: | ANY VISUAL SIGNS OF CANCER?

CHARTING INDICATES RESTORATION NEEDED DUE TO DECAY OR FRACTURE

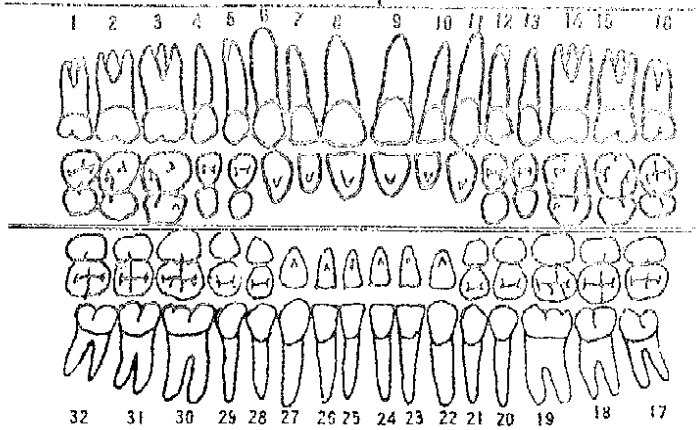


LIST MEDICATIONS INCLUDING HERBS & VITAMINS

UPDATED MEDICATIONS

DATE OF EXAM:

X-RAYS: | ANY VISUAL SIGNS OF CANCER?



DOB ___/___/___ Last 4 SS# ___

MEDICAL HISTORY

(Circle)

1. Are you having pain or discomfort at this time? . . . . . YES NO
2. Do you feel very nervous about having dentistry treatment? . . . . . YES NO
3. Have you ever had a bad experience in the dentistry office? . . . . . YES NO
4. Have you been a patient in the hospital during the past two years? . . . . . YES NO
5. Have you been under the care of a medical doctor during the past two years? . . . . . YES NO
6. Have you taken any medicine or drugs during the past two years? . . . . . YES NO
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? . . . . . YES NO
8. Have you ever had any excessive bleeding requiring special treatment? . . . . . YES NO
9. Circle any of the following which you have had or have at present:

Endocarditis	Internal Defibulator	AIDS
Heart Failure	Emphysema	Hepatitis A(infectious)
Heart Disease or Attack	Cough	Hepatitis B (serum)
Angina Pectoris	Tuberculosis (TB)	Liver Disease
High Blood Pressure	Asthma	Yellow Jaundice
Heart Murmur	Hay Fever	Blood Transfusion
Rheumatic Fever	Sinus Trouble	Drug Addiction
Congenital Heart Lesions	Allergies or Hives	Hemophilia
Artifical Heart Valve	Diabetes	Venereal Disease(Syphilis, Gonorrhea)
Heart Pacemaker	Thyroid Disease	Cold Sores
Heart Surgery	X-ray or Cobalt Treatment	Genital Herpes
Artifical Joint	Chemotherapy (Cancer, Leukemia)	Epilepsy or Seizures
Anemia	Arthritis	Fainting or Dizzy Spells
Stroke	Rheumatism	Nervousness
Kidney Trouble	Cortisone Medicine	Psychiatric Treatment
Ulcers	Glaucoma	Sickle Cell Disease
	Pain in Jaw Joints	Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . . YES NO
11. Do your ankles swell during the day? . . . . . YES NO
12. Do you use more than 2 pillows to sleep? . . . . . YES NO
13. Have you lost or gained more than 10 pounds in the last year? . . . . . YES NO
14. Do you ever wake up from sleep short of breath? . . . . . YES NO
15. Are you on a special diet? . . . . . YES NO
16. Has your medical doctor ever said you have a cancer or tumor? . . . . . YES NO
17. Do you have any disease, condition, or problem not listed? . . . . . YES NO
18. WOMEN: Are you pregnant now? . . . . . YES NO
    Are you practicing birth control? . . . . . YES NO
    Do you anticipate becoming pregnant? . . . . . YES NO

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 without fail.

_____ _____ _____

Date *Signature of Patient, Parent or Guardian*

Reviewed by _____ Signature _____

_____

Are you sensitive to any type of metal, plastic, or porcelain? If so , list which ones. _____

OFFICE CONSENT FROM

* Having been treated previously with Bisphosphonate drugs you should know that there is a significant risk of future complications associated with dental treatment.....Osteonecrosis may result.....this risk is increased after, surgery, especially from extraction; implant placement or other "invasive" procedures.....,
These complications can result if you are or have ever taken these drugs.

Have you **EVER** taken any of the following Drugs known as BISPHOSPHONATES (BPH)?

(Aredia) Pamidronate-IV (cancer)
(Zometa) Zoledronic acid-IV (cancer)
(Boniva) Ibandronate
(Actonel) Riseoronate
(Fosamax) Aiendonate

Have you ever been diagnosed or treated with the following:

* Osteoarthritis
* Prostate Disease
* Multiple Myeloma
* Soft Tissue Tumors
* Skeletal Disorders
* Paget's Disease
* Osteoporosis
* Cancer

Please list the Dr. who diagnosed or treated any of the above diseases within the last 15 years:

_____

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 without fail.

_____ _____ _____
Date Signature of Patient, Parent or Guardian

Disclosure and Consent for Dental Procedures

TO THE PATIENT: You have the right as a patient to be informed about the condition and the recommended dental or diagnostic procedure so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to scare you. It is simply an effort to better inform you about the nature of the treatment that you are to have completed.

I understand that no warranty or guarantee has been made to me as a cure or result thereof, just as there may be risks and hazards in continuing my present condition without treatment. There are also risks and hazards related to the performance of the surgical or diagnostic procedures planned for me. I realize that common to surgical and/or diagnostic dental procedures, there is a potential for infection, blood clots, excessive bleeding, allergic reactions, and even death. There may be additional risks and hazards that occur in connection with the following dental procedures: extractions, incision and drainage of abscess, endodontics, implants, gum treatments, fillings, air abrasion fillings, pulpotomys, biopsies, surgical procedures, prophylactics, crowns, bridges, dentures and all other dental procedures.

PLEASE INITIAL THE FOLLOWING ACKNOWLEDGMENTS:

_____ Post operative swelling, bruising, and discomfort. Infection may also occur which will require additional treatment and bleeding may be prolonged. There is a possibility of injury to or stiffness of neck and facial muscles. Changes in the temporomandibular joint leading to possible changes in the occlusion, bite or the teeth.

_____ Injury to the nerve underlying the teeth in the lower jaw resulting in numbness, tingling, or altered sensation of the lips, chin, gums, or teeth. Possible damage to the nerves of the tongue leading to numbness or altered sensation. This may include an alteration in taste, although usually temporary, these changes may be permanent.

_____ I understand the local anesthesia and nitrous oxide conscious sedation (laughing gas) involves additional risks and hazards. I request the use of one or both of these for the relief of pain or protection from pain during the planned dental procedure(s). I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reactions, paralysis, brain damage or even death. I also realize that medications, drugs, anesthetics, and prescriptions may cause drowsiness and a lack of awareness or coordination, which could be increased by the use of alcohol or other drugs. I agree not to operate a vehicle or any hazardous devices for at least 24 hours or until fully recovered from the effects of the prescribed medications given to me in this office for my care. I have been given an opportunity to ask questions regarding my diagnosis, procedures of treatment to be used, different forms of sedation/anesthetics and risks of non-treatment. I also agree and confirm that my plan of treatment, which includes risks and hazards, have all been fully explained to me. I now have sufficient and accurate information to give my full consent for treatment. I further certify that I have read all of the information given to me and I therefore understand it in its entirety.

_____ I understand that any and all treatments of teeth and gums have the possibilities of causing sensitivity which is usually reversible, however it is possible that root canal therapy might be necessary to resolve sensitivity of abscessed teeth. This includes tooth whitening, crowns, fillings, gum surgery, cleaning and veneering teeth.

_____ I understand that it is my responsibility to inform Dr. F.R. Boyles of any changes in my current health history. I further understand that it is my responsibility to inform Dr. F.R. Boyles of all medications that I am currently taking whether prescribed and/or over-the-counter. I must also inform Dr. F.R. Boyles of any and all allergies and sensitivities to metal, latex or any other substances.

****

Date: _____ Time: _____ a.m. / p.m.

_____
Patient Signature

_____
Responsible Party (If patient is a minor under the age of 18)

_____
F.R. Boyles D.D.S.

_____
Witness

Notice of Privacy Practice

Boyles General Dentistry

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. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information carry out treament, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Discloser Your Protected Health Information

You will be asked to sign an Acknowledgement Of Receipt Of Notice Of Privacy Practices when we give you our Notice of Privacy Practices. Once you have received our Notice, we will use your protected health information for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in you care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our pratice. Following are examples of the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activites of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information to contact you to remind you of your appointment. We may send you information about treatment alteratives or products and services that may be of interest to you. We may also use your name to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these matcrials not be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

Your Written Authorization Is Required For Other Uses Of Your Protected Health Information

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as decribed below. You may revoke this authorization at any time, in writing, except to the extent that our practice has already released your health information as provided for in your authorization.

How We Will Use Your Health Information With You Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object (such as in an emergency) to the use or disclosure of the protected health information, then we may use professional judgment and common practice to determine whether the disclosure is in your best interest. In this case, only the protected health information that is needed to provide your healthcare will be disclosed.

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, _____ have received a copy of
(Name Of Patient)

Boyles General Dentistry Notice of Privacy Practices.
(Name Of Practice)

_____
(Signature Of Patient)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgment of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason.

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other _____