Cynthia L. Hovey, D.D.S.
Exceptional Care for Everlasting Smiles

Dr. Cynthia L. Hovey, P.C.
8801 N. Meridian Street • Suite 309 • Indianapolis, Indiana 46260
(317) 844-8085 • doctorhovey.com

Dental Patient Personal History

Thank you for choosing our office. Please take a moment to tell us who referred you or how you heard about us.

_____

_____

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Child

Name: _____ Social Sec #: ___ - ___ - ___ Birth Date: _____ Age: _____
(LAST) (FIRST) (MIDDLE)

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Business Phone: _____

E-mail Address: _____

If Patient is a Child, Parent or Guardian: _____ Emergency Contact: _____

Occupation: _____ Employer: _____

Do you have Dental Care Benefits? ❑ Yes ❑ No

If Yes, name of Dental Benefit Provider(s): _____

Secondary Dental Benefit Provider, if covered: _____

Person Responsible for Dental Care Benefits

Name, if other than Patient information above: _____

Address, if different from above _____ City: _____ State: _____ Zip: _____

Social Sec #: ___ - ___ - ___ Birth Date: _____

Acceptance of Privacy Policy

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION
PLEASE READ THE FOLLOWING STATEMENTS CARFEULLY

PURPOSE OF CONSENT: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters concerning your protected health information. A copy of our notice accompanies this consent, upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this consent.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM PERTAINING TO OUR PRIVACY PRACTICES. I UNDERSTAND THAT BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION.

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

PLEASE COMPLETE BOTH SIDES

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Patient Medical & Dental Care History

Are you having any pain or discomfort at this time? ❑ Yes ❑ No

What is your present health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please check any of the following which you have had or have at present.

- ❑ Heart Condition
- ❑ Heart Attack or Stroke
- ❑ Chest Pains (Angina)
- ❑ Heart Surgery
- ❑ Artificial Heart Valve
- ❑ High Blood Pressure
- ❑ Psychiatric Treatment
- ❑ Drug Addiction
- ❑ Heart Pacemaker
- ❑ Anemia or Hemophilia
- ❑ Bruise Easily
- ❑ Shortness of Breath
- ❑ Swelling of Ankles
- ❑ Artificial Joint (Hip, Knee, etc.)
- ❑ Lung Disease
- ❑ Emphysema
- ❑ Asthma or Hay Fever
- ❑ Tuberculosis (T.B.)
- ❑ Skin Rashes or Hives
- ❑ Kidney Trouble
- ❑ Diabetes
- ❑ Sickle Cell Disease
- ❑ Liver Disease
- ❑ Hepatitis A (Infectious)
- ❑ Hepatitis B (Serum)
- ❑ Allergies
- ❑ Blood Transfusion
- ❑ Thyroid Disease
- ❑ Cortisone Medicine
- ❑ Glaucoma
- ❑ Arthritis or Rheumatism
- ❑ Pain in Jaw Joints
- ❑ Fainting or Dizzy Spells
- ❑ Alcoholism
- ❑ Yellow Jaundice
- ❑ Cancer or Tumor
- ❑ Radiation Therapy (not dental x-rays)
- ❑ Chemotherapy
- ❑ HIV Positive / AIDS
- ❑ Venereal Disease
- ❑ Genital Herpes
- ❑ Cold Sores
- ❑ Epilepsy or Seizures

Name of your regular dentist: _____

How long has he/she been your dentist? _____

Reason for this dental visit? _____

When was your last dental cleaning examination? _____

Do you have any diseases, conditions or problems not listed above? ❑ Yes ❑ No

If Yes, please explain. _____

Are you nervous about dental treatment? ❑ Yes ❑ No

Are you currently taking any medications or drugs? ❑ Yes ❑ No

If Yes, please list drugs(s), dosage and frequency. _____

_____

_____

Are you allergic to any medicine, drug or other substances? ❑ Yes ❑ No

If Yes, please explain. _____

Do you have a latex allergy? ❑ Yes ❑ No

Have you ever taken any bisphosphonates (osteoporosis drugs)? ❑ Yes ❑ No

Are you now, or have been, under the care of a physician? ❑ Yes ❑ No

Have you ever been hospitalized or had a surgery? ❑ Yes ❑ No

Have you ever had a reaction to local anesthetic? ❑ Yes ❑ No

Have you ever had prolonged or excessive bleeding? ❑ Yes ❑ No

Have you ever had complications or illness following dental treatment? ❑ Yes ❑ No

Have you ever had an injury or trauma to your face or jaw? ❑ Yes ❑ No

Has your physician told you to take an antibiotic before any dental treatment? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Do you use tobacco products? ❑ Yes ❑ No

If Yes, how much? _____

Women:

Are you pregnant now? ❑ Yes ❑ No

If Yes, your due date: _____

Are you taking oral contraceptives? ❑ Yes ❑ No

Please check Dental Treatment(s) Desired:

- ❑ Cleaning/Exam
- ❑ Replace missing teeth
- ❑ Dentures
- ❑ Teeth Whitening
- ❑ Bridgework
- ❑ Cavities restored
- ❑ Extract teeth
- ❑ Partial(s)
- ❑ Orthodontics
- ❑ Consultation

Comments: _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.
IF MY HEALTH OR MEDICINES CHANGE, I WILL INFORM THE DENTAL OFFICE OF DR. CYNTHIA L. HOVEY, DDS DURING MY NEXT APPOITNMENT.
Thank you for choosing our office for your dental care needs!

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

PLEASE COMPLETE BOTH SIDES