KEELAN DENTAL

Medical History

Name of Primary Care Physician

Phone Number of Physician

Date of Last Exam

Name of Specialty Provider

Phone Number of Specialist

Date of Last Exam

Preferred Pharmacy

By signing below, the patient consents for the office to retrieve their medical history. (This enables our doctors to observe allergies, possible interaction with other medications, etc. when prescribing medications to you.)

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been hospitalized?*

☐ Yes ☐ No

If yes, please explain:

Are you subject to frequent headaches?*

☐ Yes ☐ No

If yes, please explain:

Are you currently pregnant?*

☐ Yes ☐ No

If pregnant, when is your due date?

Are you currently breastfeeding?*

☐ Yes ☐ No

Do you currently smoke, vape, or use smokeless tobacco?*

☐ Smoke ☐ Vape ☐ Smokeless Tobacco

☐ Not Applicable

If yes, how many years have you smoked, vaped and/or used smokeless tobacco?

If yes, how often do you smoke, vape, or use smokeless tobacco?

Do you currently drink alcohol?*

☐ Yes ☐ No

If yes, please select the appropriate response.

☐ Less than 1 drink per month

☐ 1-3 drinks per month

☐ 1-3 drinks per week

☐ 1-3 drinks per day

Allergies (Check all that apply)*

- ☐ Acetaminophen
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Ceclor
- ☐ Codeine
- ☐ Doxycycline
- ☐ Erythromycin
- ☐ Fluoride
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Keflex
- ☐ Latex
- ☐ Local Anesthesia with Epinephrine
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Not Applicable

Please explain any unlisted allergies:

Medical Conditions (Check any that you have at the present or have had in the past.)*

- ☐ ACE Inhibitor
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer - Existing
- ☐ Cancer - Melanoma
- ☐ Cancer - Treated
- ☐ Cholesterol
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High / Low Blood Pressure
- ☐ HIV
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumps in Mouth
- ☐ Mental Disorders
- ☐ Mitral-Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Issues
- ☐ STD
- ☐ STI
- ☐ Stomach Issues
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ Not Applicable

Please explain any unlisted medical conditions. (Use the back of this page if more space is needed.)

Active Medications (Check all that apply)*

- ☐ Birth control
- ☐ Blood Thinners
- ☐ Dietary Supplements
- ☐ Erectile Dysfunction Medication
- ☐ Fosamax
- ☐ Osteoporosis Medication
- ☐ Premedication
- ☐ Weight Control
- ☐ Not Applicable

List any current medications and / or medications taken within the last two years.

Describe any current medical treatment, impending surgery, or other treatment.

Patient Information

Please input the patient's information below.
If you are completing this form on behalf of the patient, please also complete the "Legal Guardian" section on page 6.

First Name * | Last Name * | MI | Patient's Preferred Name

Date of Birth *

Gender *
☐ Female ☐ Male

Family Status *
☐ Married ☐ Single ☐ Child ☐ Divorced ☐ Widowed ☐ Other_____

Wireless Phone Number * | Home / Secondary Number | E-Mail Address *

Mailing Address *

City * | State * | Zip Code *

Emergency Contact Name * | Emergency Contact Phone Number * | Relation to Patient *

If someone other than the patient is the legal guardian or responsible for payment, please complete.

Legal Guardian Information

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number | Relation to Patient

Wireless Phone Number | Home / Secondary Number | E-Mail Address

Mailing Address

City | State | Zip Code

Person Responsible for Payment Information

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number | Relation to Patient

Wireless Phone Number | Home / Secondary Number | E-Mail Address

Mailing Address

City | State | Zip Code

Acknowledgement

☐ By checking this box, I acknowledge that the above information is correct. I understand that it is my responsibility to inform Keelan Dental of any changes to this information.

Today's Date*

Signature*

KEELAN DENTAL

Notice of Privacy Practices

Keelan Dental safeguards your protected health information using the following procedures:

- We use secure servers and drives to store your electronic health information.
- We contract an outside company to destroy your physical health information when it is no longer needed.
- We place barriers and require passwords to prevent unauthorized access to your health information.
- Our employees sign a non-disclosure agreement and receive HIPAA Privacy/Security Law education.
- We are required to notify you of any breaches of the privacy of your health information.

Primary reasons Keelan Dental uses or discloses your protected health information:

- We will share your health information with our staff to ensure the highest quality of care, help run our practice efficiently, and contact you about treatment.
- We will share your health information with other healthcare professionals, if needed for your care.
- We will share your health information with health insurance companies, or similar entities, to bill and receive payment for services.
- We will share your health information if we believe your life is at risk if the information remains unshared.
- Technicians working in the office or remotely will have access to your health information. A business associate agreement is in effect when they require access to this information for maintenance.

Other reasons Keelan Dental may use or disclose your protected health information:

- We may share your health information for public health and safety.
- We will share your health information if the law requires it.
- We may share your health information for: medical examiners, law enforcement, worker's compensation purposes, national health or security concerns, relevant lawyers.
- We may share your health information if you give us written consent to share it with individuals or entities other than yourself.
- We may share your health information with family members listed in your family file unless you have notified us otherwise in writing.
- We may share your health information with third-party software providers to help our business run efficiently.

You have the following rights pertaining to your protected health information:

- Obtain a copy of your health information at Keelan Dental
- Correct an error in your medical records
- Request confidential communication of medical records
- Ask us to limit the information we share
- Ask us with whom we have shared your information
- Receive a copy of our privacy notice (this document)
- Choose someone to act in your stead
- Submit a formal complaint to Health and Human Services

Keelan Dental may update this privacy policy at any time. If you have any questions about how your healthcare information is used or would like an updated copy of this notice, please see the concierge or contact our office.