HEALTH HISTORY RECORD

FRANK T. CURRY, D.D.S., INC.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completlely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Name: (LAST) _____

Mr. Mrs. Ms. Dr. (FIRST) _____ (M.I.) _____

I prefer to be called: _____

Birthdate: ____ | ____ | ____ ☐ Female ☐ Male

SS#: _____ DL#: _____

Home Address: _____

_____

_____

☐ Single ☐ Married ☐ Other

Hm#: ( ) _____ Other#: ( ) _____

Wk#: ( ) _____ Ext: ____ Pgr: ( ) _____

Fax#: ( ) _____ E-mail: _____

Employer: _____

Employer's Address: _____

_____

How long there? _____ Occupation: _____

If Minor, Name of School: _____

Where & when are the best times to reach you?

_____

Other family members seen by us: _____

Previous/Present Dentist: _____
(Please circle)

Phone#:( ) _____ Last Visit Date: _____

Whom may we thank for referring you?

_____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk#: ( ) _____ Ext: ____ DOB: ____ | ____ | ____

SS#: _____ DL#: _____

Neighbor or Relative not living with you.

His/Her Name: _____ Relation: _____

Wk#: ( ) _____ Hm#: ( ) _____

Address: _____

_____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

_____

Insurance Co. Phone #: _____

Group #: (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

Insured's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

_____

Insurance Co. Phone #: _____

Group #: (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

Person Responsible for Account: _____

_____

Wk#: ( ) _____ Ext: ____ Hm#: _____

Billing Address: _____

_____

Relationship: _____

Employer: _____

SS#: _____ DL#: _____

FINANCIAL

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If the office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature Date

MEDICAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription drugs? ☐ Yes ☐ No

Please list: _____

_____

Have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week# _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Heart Surgery
Y	N	Alcohol/Drug Abuse	Y	N	Hepatitis
Y	N	Anemia	Y	N	Herpes/Fever Blisters
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Bones/Joints/Valves	Y	N	HIV+/AIDS
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Sinus Problems
Y	N	Frequent Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Ulcers

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Other
Y	N	Codeine	Y	N	Latex			
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any drugs that you are allergic to: _____

_____

MEDICAL HISTORY CONTINUED

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Address: _____

_____

Phone#: ( ) _____ Date of last visit: _____

DENTAL HISTORY

What is your primary dental concern(s)?

_____

_____

_____

Do you need to be premedicated before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had periodontal treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Are your teeth sensitive to heat, cold or anything else? _____

Do you like your smile? ☐ Yes ☐ No

Please explain: _____

_____

_____

_____

I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

AREA BELOW THIS LINE IS FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated ____ and confirmed that it states past and present medical condtions. _____
Signature Date

I have read my medical history dated ____ and confirmed that it states past and present medical condtions. _____
Signature Date

I have read my medical history dated ____ and confirmed that it states past and present medical condtions. _____
Signature Date

Frank T. Curry, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will 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 about your protected health information. A copy of our Notice accompanies this Consent. 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. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting:

Frank T. Curry, DDS
1901 Westcliff Drive, Suite 8
Newport Beach, CA 92660
Phone: 949-631-2490 Fax: 949-631-5708 E-mail: ftcurry@pacbell.net

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Frank T. Curry, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement 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)_____

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I,_____, acknowledge I have
patient name
received from Dr._____ a copy of the Dental Materials Fact Sheet dated October 17, 2001.

_____ _____
Patient Signature *Date*

The Dental Board of California

Dental Materials Fact Sheet

Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Temporomandibular Joint Dysfunction (TMJ) *Questionnaire*

Name: _____

Age: _____

Referred by: _____

1. **Describe your problem:**

2. **Which side hurts?** ❑ Right ❑ Left ❑ Both

   For how long:

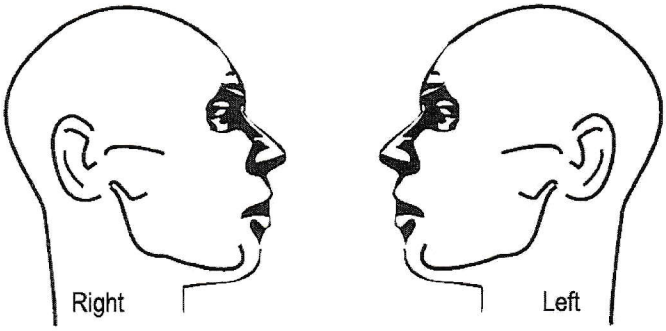
3. **Is the pain constant or intermittent?**

4. **When is the pain worse?** ❑ Morning ❑ Afternoon ❑ Evening

5. **Does it hurt to move your jaw?** ❑ Yes ❑ No

6. **Does it hurt to chew?** ❑ Yes ❑ No

7. **On the figures to the right, please outline where your pain is located.**



8. **Does your jaw make noise?** ❑ Clicking ❑ Grinding ❑ Other

   When: For how long:

9. **Has your jaw ever locked open?** ❑ Yes ❑ No

10. **Has your jaw ever locked closed?** ❑ Yes ❑ No

    When: How often:

11. **If your jaw does not make noise or lock now, has it ever in the past?** ❑ Yes ❑ No

12. **Have you ever suffered from?**

    ❑ Headaches ❑ Neckaches ❑ Shoulder Pain

    ❑ Ear Pain ❑ Dizziness ❑ Change in Hearing

Turn over...

13. **Do you grind or clench your teeth?** ❑ At night ❑ During the day

14. **Do you have sore or sensitive teeth?** ❑ Yes ❑ No ❑ Sometimes

15. **Do you have trouble getting to sleep?** ❑ Yes ❑ No ❑ Sometimes

16. **Do you sleep well?** ❑ Yes ❑ No ❑ Sometimes

17. **Do you consider yourself to be under a lot of stress?** ❑ Yes ❑ No ❑ Sometimes

18. **Are you nervous or anxious about anything?** ❑ Yes ❑ No ❑ Sometimes

19. **Have you had a nervous stomach, ulcers, skin disease?** ❑ Yes ❑ No ❑ Sometimes

20. **Do you have or have you ever had arthritis?** ❑ Yes ❑ No ❑ Sometimes

21. **Does your pain keep you from doing anything?** ❑ Yes ❑ No If yes, what?

22. **Can you remember any injury to your jaw?** ❑ Yes ❑ No If yes, describe:

23. **Do you take medications for the pain?** ❑ Yes ❑ No If yes, what?

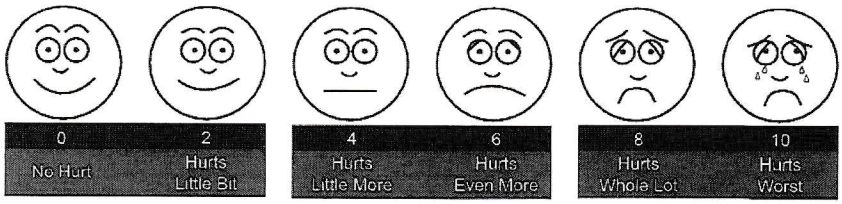
24. **Do you take medications for relaxation?** ❑ Yes ❑ No If yes, what?

25. **Have you had any treatments for your problem?** ❑ Yes ❑ No

26. **Please check any treatments you have had:**

❑ Bite splint	❑ Medication	❑ Physical therapy	❑ Counseling
❑ Occlusal adjustment	❑ Orthodontics	❑ Surgery	❑ Other:

27. **Rate your pain now:**



28. **At its worst, how bad was the pain?**