50154 Schoenherr Road
Shelby Twp., MI 48315

JOSEPH M. HILDEBRAND, D.D.S.
Dr. Hadi A. Khazaal, M.D., D.D.S.
ORAL AND MAXILLOFACIAL SURGERY

P (586) 731-9050
F (586) 731-9056

Health History Form

Patient's Name _____ Date of Birth ____/____/_____

Gender: Male / Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are having today: _____

Has there been any change in your health in the past year? Yes No

If yes please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes why? _____ Date of last physical exam ____/____/_____

Have you been hospitalized or had a serious illness? Yes No

If yes why? _____

Emergency Contact Print Name _____ **Phone No.** (____) _____

PATIENT MEDICAL HISTORY *Do you have or have you ever had:*

Congenital heart disease, cardiovascular disease heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker) Yes No

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Yes No
Do you pre-medicate? Yes No

Kidney disease or kidney failure, requiring dialysis? Yes No

Thyroid disease? Yes No

Stomach ulcers or colitis? Yes No

Clicking, popping, or pain within the jaw and/ or difficulty opening your mouth? Yes No

Frequent or recurring mouth sores? Yes No

Radiation to the head or neck for cancer treatment? Yes No

Any disease, chemotherapy or transplant operation? Yes No

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Yes No

Malignant hyper-thermia? Yes No

Glaucoma? Yes No Wear Contacts? Yes No

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Yes No
Do you bruise easily? Yes No

Liver disease (jaundice, hepatitis A or B or C)? Yes No

Diabetes? Type 1 or Type 2 Yes No

Arthritis? Yes No

Significant weight loss or gain? Yes No

Seizures, convulsions, epilepsy, fainting or dizziness? Yes No

Sinus or nasal problems? Yes No

Osteoporosis or osteopenia? Yes No

Sleep Apnea Yes No

If so, where?_____, and when was the date of your last treatment?____/____/_____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No • Nursing? Yes No

Are you taking Birth Control Pills? Yes No

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

Do you wish to talk to the doctor privately about anything? Yes No Are you wearing removal dental appliances? Yes No

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frontdesk@drjhildebrand.com

PATIENT REGISTRATION

Name _____ Marital Status _____ Male ___ Female ___

DOB ___/___/_____ Age ____ SSN# _____ Employer _____

Home Address _____ City/ State _____ Zip _____

Home Phone ( )_____ Business Phone ( )_____ Mobile Phone ( )_____

Student Yes __ No __ Full Time __ Part Time __ Name of School _____ Location _____

Spouse's Name _____ DOB ___/___/_____ SSN# _____ Employer _____

Email Address _____

INSURANCE INFORMATION

Name of Primary Dental Insurance _____ Subscriber _____

Name of Secondary Dental Insurance _____ Subscriber _____

Name of Primary Medical Insurance _____ Subscriber _____

Name of Secondary Medical Insurance _____ Subscriber _____

Have you had a full mouth set of x-rays or a panorex within the past three (3) years? ____ Where? _____

Name of General Dentist _____ Name of Primary Care Physician/ Doctor _____

Who may we thank for referring you to our practice? _____

FILL IN THIS PORTION ONLY IF THE PATIENT IS COVERED BY PARENT'S INSURANCE OR IS A MINOR

Father's Name _____ SSN# _____ DOB ___/___/_____

Father's Address _____ City/ State _____ Zip _____

Father's Employer _____ Business Phone Number (___) _____

Mother's Name _____ SSN# _____ DOB ___/___/_____

Mother's Address _____ City/ State _____ Zip _____

Mother's Employer _____ Business Phone Number (___) _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

If you have any dental and / or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.

Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge.

It's your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

You will be responsible for all collection costs, attorney's fees, and court costs.

Signature _____ *Date* _____

MACOMB ORAL SURGERY

Dr. Jospeh M. Hildebrand, DDS, PC

Dr. Hadi Khazaal, MD, DDS

50154 Schoenherr Road

Shelby Twp., Mi 48315

PHARMACY INFORMATION

PLEASE, NO CVS OR RITE AID – IF YOU INSIST, YOU MAY NOT RECEIVE OPIOID FOR EXCEEDED PAIN DUE TO SHORTAGE.

PATIENT'S NAME: _____

DATE: _____

DOB: _____

PHARMACY NAME: _____

ADDRESS: _____

_____ cross road _____

TELEPHONE NUMBER: _____

Allergies: _____

Blood Thinners: _____

Other: _____

PLEASE MAKE SURE THIS FORM IS COMPLETED

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Notice of Privacy Practices

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.

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 that are described in this Notice while it is in effect. This Notice takes effect April 1, 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 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 the Notice, please contact us using the information at the end of this Notice.

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 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 to those described in this Notice.
To 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 you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
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 Communications: 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 payment 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 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 (Email), you are entitled to receive this Notice in written form.
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 capacity 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.

Continued on the Reverse Side

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please **print** name of Patient Please **sign** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgments or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name _____ Relationship _____

Name _____ Relationship _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA omnibus Rule, provide you this information with your knowledge and consent.

Office use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment ___
I could not communicate with the patient ___
The patient refused to sign ___
The patient was unable to sign because _____

Other (please describe) _____

_____
Signature of Privacy Officer

Health History Form Side 2

MEDICATIONS *Are you using any of the following:*

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No
If Yes, Medication Name: _____

Physician Name & Address _____

_____

Last INR Reading & Date _____

Heart Drugs? Yes No _____

Aspirin or drugs such as Motrin, Aleve, ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

High blood pressure medications? Yes No

Biophosphonates, antiangiogenic and/ or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If Yes list drugs used and time of use. Yes No

_____

_____

Steroids (cortisone, prednisone, etc)? Yes No _____

Antianxiety agents, sedative-hypnotics or antidepressants? Yes No _____

Prescription pain medications? Yes No Please list _____

_____

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:_____

ALLERGIES *Are you allergic to or have you had an adverse reaction to:*

Latex? Yes No • Food Products? Yes No • Sedatives, barbiturates? Yes No • Iodine Yes No

Aspirin, Motrin, Aleve or ibuprofen? Yes No • Penicillin, Amoxicillin, sulfa, or other antibiotics? Yes No

Other drug allergies not listed above. _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If Yes, for how long? _ _____ Vaped? Yes No

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No * Emotional disorders? Yes No

Alcoholism? Yes No

Are you under the care of a pain management clinic? Yes No

Do you use:

Alcohol? Yes No How Often? _____

Marijuana/ Medical? Yes No How Often? _____

Recreational drugs? Yes No How Often? _____

List any medications taken for drug abuse: _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent or guardian Date

_____ _____
Printed name of patient, parent or guardian and relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date For completion by the Doctor Doctor's Signature

_____

_____

_____

_____