**Northland Dental Studio**
**YEARLY PATIENT INFORMATION UPDATE**

FIRST NAME: ____________________________________ LAST NAME: ________________________________________________NICKNAME: _________________

ADDRESS: ________________________________________________________________ CITY: __________________________ STATE: __________ ZIP:_______________

SEX: M F MARITAL STATUS: M S D W **SOC. SEC.** #:___________________________________**DOB**:_______________________________________

**CELL PHONE**:_______________________________ HOME PHONE(landline):_________________________**E-MAIL**:_______________________________________

*IN CASE OF EMERGENCY PLEASE NOTIFY___________________RELATIONSHIP TO PATIENT:____________________ PHONE:_________________________

ANY CHANGES TO YOUR DENTAL INSURANCE: YES NO IF YES- DENTAL INSURANCE NAME:_________________________

SUBSCRIBER'S NAME: ______________________________________________SUBSCRIBER'S DOB:_______________ RELATIONSHIP TO PATIENT:__________________

**SUBSCRIBER ID/SS#**:____________________________________________________ GROUP/PLAN#_________________________________________________________

Current Tobacco Product use? Yes__No___ If yes,what products do/did you use?________ E-Cigs ? Yes______No______

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? ***( please circle "Y" or "N", or bold "Y " or "N" for each condition )***

| | | | |
|---|---|---|---|
| Y N Blood disorders | Y N Stroke | Y N Diabetes | Y N Fainting |
| Y N Heart disease | Y N Lung disease | Y N Epilepsy | Y N Arthritis |
| Y N Heart attack | Y N Tuberculosis | Y N Anemia | Y N Seasonal Allergies |
| Y N Heart murmur | Y N Asthma | Y N Tumor history | Y N Pregnant if yes, due date____________ |
| Y N Rheumatic fever | Y N Liver disease | Y N Artificial joints | Y N Glaucoma |
| Y N Chest pains (Angina) | Y N Hepatitis | Y N High blood pressure | Y N Herpes Simplex Virus |
| Y N AIDS / HIV+ | Y N Kidney disease | Y N Low blood pressure | Y N Human Papilloma Virus |
| Y N Padget's Disease | Y N Multiple Myeloma | Y N Thyroid Issues | Y N Gum Disease, did you receive treatment? Y N |
| Y N Systemic Lupus | Y N Acid Reflux | Y N Eating Disorder | Y N Osteoporosis |
| Y N Sleep Apnea | Y N Cancer | Y N Psychiatric treatment | Y N Bisphosphonate Drug Use (Osteoporosis Drug) |

OTHER SYSTEMIC CONDITIONS/ Please explain any checked conditions: ______________________________________________________

**MEDICATION ALLERGIES** (please check all that apply) No Known Drug Allergies ____ Amoxicillin_____ Aspirin____ Clindamycin____

Codeine____ Erythromycin____ Ibuprofen____ Penicillin____ Other:_______________________________________________________

ARE YOU TAKING ANY DRUGS, MEDICATION, OR PILLS? Y N Please list with reason for each medication

_____________________________________________________________________________________________

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N EXPLAIN: ____________________________________________

**RESPONSIBLE PARTY SIGNATURE** _________________________________________DATE _______________________

**DOCTOR SIGNATURE** ______________________________________ DATE BP____/_____ P______

***HIPAA Policy, Texas SB-300 and Consent***

**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.
**Patient Communications:** With this consent I hereby give Northland Dental Studio permission to contact me via US Postal service, e-mail and telephone (home/cell/work and permission to leave a message on voice mail or in person) in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations) such as appointment reminders, insurance items, statements, marketing material and any calls pertaining to my clinical care.
**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 before signing the Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our 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 and revisions of our Notice, at any time by contacting our office.
**Right to Revoke**: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat or continue treating you if you revoke this Consent.
I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices, I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.
**Signature:**____________________________________________**Date:**___________________________