MEDICAL HEALTH HISTORY

Rippe Dental Associates
13111 E. Briarwood Ave # 225
Centennial CO 80112

PATIENT NAME: _____
DATE: _____

Date of last health care exam: _____What was this exam for? _____
Have you ever been hospitalized or had a major operation? Discuss: _____
Have you been hospitalized in the past 5 years? : _____If yes, reason: _____
Have you ever had a serious injury to your head or neck? Discuss: _____
Are you currently under a physician's care? : _____If yes, reason: _____
Physician's Name: _____ Phone Number: _____

Do you have or have you ever had any of the following? Please circle appropriately.

If yes to any of the starred (*) conditions, please call prior to your appointment…premedication may be required.

*Artificial Heart Valve	Angina/Chest Pain	Swelling of Limbs	Liver Disease	Lung Disease	Tattoos
*Sub-acute Bacterial Endocarditis (Heart Infection)	Rheumatic Fever or Scarlet Fever	Chemotherapy or Radiation Therapy	Hepatitis A (Infectious) Hepatitis B or C	Emphysema Frequent Cough	Oral Herpes Fever Blisters/Cold Sores
*Heart Transplant	Mitral Valve Prolapse	Cancer	Yellow Jaundice	Sinus Trouble	Night Sweats
*Congenital Heart Disorder	Heart Pace Maker	Previous Biopsies	Osteoarthritis/Arthritis	Breathing Problem	Unexplained Fever
*Artificial Joint (hip, knee, etc.)	Recent Blood Transfusion	Sore/Enlarged Lymph Nodes	Rheumatoid Arthritis (Rheumatism)	Shortness of Breath Asthma	Alcoholism or Drug Addiction
Heart Trouble/Disease	Blood Disease	Tumors	Pain in Jaw Joints	Tuberculosis	Venereal Disease
Heart Attack/Failure	Abnormal Bleeding	Recent Weight Loss	Kidney Disease	Bloody Sputum	HIV Positive
Heart Murmur	Bruise Easily	Frequent Diarrhea	Kidney Problems	Hay Fever	AIDS
Heart Stent	Excessive Bleeding	Ulcers	Renal Dialysis	Glaucoma	Recurrent Illnesses
Heart Surgery	Sickle Cell Disease	Stomach/Intestinal Disease	Stroke	Psychiatric Care	Parathyroid Disease
Irregular Heart Beat	Hemophilia	Diabetes	Fainting or Dizziness	Depression	Thyroid Disease
High Blood Pressure	Leukemia	Excessive Thirst	Convulsions	Psychosis	Allergies to Pollen/Dust
Low Blood Pressure	Anemia	Hypoglycemia	Epilepsy or Seizures	Nervousness	Allergies to Medication

Are you taking any of the following medications? Please circle appropriately.

Antacids, Tagamet® (Cimetidine) or Prilosec® (Omeprazole)	Dilantin® or Tegretol® or Biaxin® (Clarithromycin) or Serzone® (Nefazodone)
Barbiturates or St. John's Wort or Kava-Kava	Pre-Medication Before Dental Treatment
Cardizem® (Diltiazem) or Calan, Isoptin® (Verapamil)	Diflucan® (Fluconazole) or Sporonox®

Have you been treated with Bisphosphonate drugs for osteoporosis or bone cancer (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did treatment begin? When did treatment end?	Yes	No
Have you ever taken prescription drugs such as Fen-Phen for weight loss?	Yes	No
Do you consume grapefruit juice, grapefruits or grapefruit extract?	Yes	No

***Please list any medications you are currently taking and dosages:**

_____
_____

***Please list any dietary or herbal supplements you are taking, and for what purpose:**

_____
_____

Are you allergic or have you had a reaction to any medications or substances? Please circle appropriately.

Acrylic	Aspirin	Codeine	Ibuprofen	Latex/Rubber	Local Anesthetic: Nova Caine, Lidocaine, other
Metal	Penicillin	Sulfa Drugs	Tylenol	Valium	Other – Please Specify:

Women:
Are you pregnant? _____If no, are you planning to get pregnant in the near future? _____
Are you a nursing mother? _____Are you taking birth control pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify Dr. Rippe DDS of any change in my health and medication.

_____ **X** _____ _____
Patient or Guardian (Print Name) **Patient Signature (Parent or Guardian)** **Date**

Dr. Christian D. Rippe DDS/Dr. Peter Huettner___ _____ _____
Doctor (Print Name) **Doctor Signature** **Date**

(Office use only) Blood Pressure_____ **Pulse**_____ **SPaO2**_____**%**

PAGE 2- MEDICAL HEALTH QUESTIONAIRRE

Tobacco, Alcohol, Drugs:

Do you use tobacco? _____Do you smoke or chew? _____ How much per day? _____ For how long? _____
Do you want to quit using tobacco? _____
Do you consume alcohol? _____ If yes, how many alcoholic beverages per week? _____
Do you use any mood altering drugs other than those previously listed? _____

Weight & Diet Considerations:

Are you on a special diet? Discuss: _____
How many meals do you eat per day? _____ Do you have any dietary restrictions? _____
Do you have any food allergies? _____
Weight: _____lbs.

***Sugar in your diet (circle one): None Slight Moderate High**

Blood Pressure:

Do you have abnormal blood pressure? _____
Have you ever received a diagnosis of "high blood pressure"? _____
What is your normal blood pressure? _____

Patient or Guardian Initials_____

Doctor's Initials_____

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____
_____
_____
_____

Significant findings from questionnaire or oral interview:

_____
_____
_____
_____

(OFFICE USE ONLY)

MEDICAL UPDATES:

DATE	EXCEPTIONS	(CIRCLE)	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		NONE				**Dr.**
		NONE				**Dr.**
		NONE				**Dr.**
		NONE				**Dr.**
		NONE				**Dr.**
		NONE				**Dr.**

Rippe Dental Associates

13111 E. Briarwood Ave
Suite 225
Centennial, CO 80112

Phone: (303) 779-9876
Fax: (303) 221-3635

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:

Address:

Telephone: Email:

Patient #: _____ Social Security #: _____

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 the 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 any time by contacting:
Jeannie Copple - Phone: (303) 779-9876 - Fax: (303) 221-3635 - cdr@drrippe.com - 7180 E. Orchard Rd. Suite 301 – Centennial, CO 80111

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.

SIGNATURE:
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 options.

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.

Personal Information

First Name: _____ Last Name: _____ Middle Initial:_____
Preferred Name:_____ Address: _____
City, State, Zip:_____
Home Phone: _____ Work Phone:_____ Cell Phone:_____
Male ❍ Female ❍ Minor ❍ Single ❍ Married ❍ Domestic Partner ❍
Birthdate:_____ Social Security # _____
Employer:_____ Occupation:_____
Who may we thank for referring to our office? _____
E-mail address:_____
Rippe Dental Associates has permission to contact me via: E-mail ❍ Phone ❍ Text Message ❍ Mail ❍
Emergency Contact:_____

Responsible Party

Who is responsible for the account: _____
Name:_____
Relationship to patient:_____ Birthdate:_____ Driver's License #:_____
Social Security #:_____ E-address: _____
Address:_____
City, State, Zip: _____
Employer:_____ Occupation: _____

Primary Insurance Information

Name of insured:_____ Relationship to patient:_____
Insured's Birth Date: _____ Insured's Social Security #:_____
Employer:_____ Date Employed:_____ Occupation:_____
Insurance Company:_____
Claims/ Insurance Company Address: _____
City, State, Zip:_____
Group #:_____ Member ID:_____
Secondary Insurance Company:_____
Claims/ Insurance Company Address: _____
City, State, Zip:_____
Group #:_____ Member ID: _____

Consent:
I understand that responsibility for payment of dental services in this office for myself and dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at a rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Rippe Dental Associates. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability act of 1996. I hereby authorize Rippe Dental Associates and its employees, agents, and assignees to contact me via email, text messaging, and to my cellular devices.

Responsible Party's Signature: _____ Date: _____