

**MERCY
DENTAL** PLLC

Audio and Video Consent Form

I, _____ parent of:

Patient of Mercy Dental, am authorizing the organization/clinic/individual
to: _____

Audio
Video
Photograph

To protect and serve the community as patients of
Mercy Dental

Patients Signature(if applicable) _____

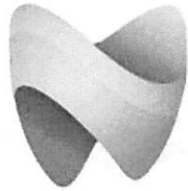
Guardian Signature(if applicable) _____

Date: _____

Employee Signature: _____

Job Title: _____

Date: _____



**MERCY
DENTAL** PLLC

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

1. Dental Practice Covered by this Notice

This Notice describes the privacy practice of Mercy Dental ("Dental Practice"). "We" and "Our" means the Dental Practice. "You and "your" means our patient.

2. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Mercy Dental's Privacy Official

1905 E. Monte Cristo Rd.
Edinburg, TX 78542
(956)-720-4504

3. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

We are required by law to:

- . Maintain the privacy of your protected health information
- . Give you this Notice of our legal duties and privacy practices with respect to that information; and abide by terms of our Notice that is currently effect.

4. Last Revision Date

This Notice was last revised on _____, 2015

Signature: _____

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urine more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?		
If so, please describe: _____		

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Women

	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Notes: _____

Patient/Parent Signature: _____

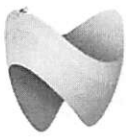
Dentist Initial: _____

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes: _____

Date: _____



Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____
Home address: _____ City: _____ State: _____ Zip: _____
Billing address (if different): _____ City: _____ State: _____ Zip: _____
Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____
SS #: _____ Employer/Occupation: _____ Bus. Phone: _____
Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____
Primary dental insurance: _____ Group #: _____
Secondary dental insurance: _____ Group #: _____
Subscriber's name: _____ Date of birth: _____ SS #: _____
Name of your medical doctor: _____ Date of last visit to medical doctor: _____
Name of previous dentist: _____ Date of last visit to dentist: _____
Referred to us by: _____

DENTAL HEALTH HISTORY

Yes No
Are you apprehensive about dental treatment?
Have you had problems with previous dental treatment?
Do you gag easily?
Do you wear dentures?
Does food catch between your teeth?
Do you have difficulty in chewing your food?
Do you chew on only one side of your mouth?
Do you avoid brushing any part of your mouth because of pain?
Do your gums bleed easily?
Do your gums bleed when you floss?
Do your gums feel swollen or tender?
Have you ever noticed slow-healing sores in or about your mouth?
Are your teeth sensitive?
Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids?
Cold foods or liquids?
Sours?
Sweets?
Do you take fluoride supplements?
Are you dissatisfied with the appearance of your teeth?
Do you prefer to save your teeth?
Do you want complete dental care?

Yes No
How often do you brush?
How often do you floss?
Does your jaw make noise so that it bothers you or others?
Do you clench or grind your jaws frequently?
Do your jaws ever feel tired?
Does your jaw get stuck so that you can't open freely?
Does it hurt when you chew or open wide to take a bite?
Do you have earaches or pain in front of the ears?
Do you have any jaw symptoms or headaches upon awaking in the morning?
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
Do you find jaw pain or discomfort extremely frustrating or depressing?
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?
Do you have a temporomandibular (jaw) disorder (TMD)?
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?
Are you unable to open your mouth as far as you want?
Are you aware of an uncomfortable bite?
Have you had a blow to the jaw (trauma)?
Are you a habitual gum chewer or pipe smoker?