Shirley E. Cagle D.D.S.

6769 LAKE WOODLANDS DRIVE, SUITE A
THE WOODLANDS, TEXAS 77382
(281) 681-9442

HEALTH HISTORY FORM

Patient Information (Confidential)

Name_____ ☐ Male ☐ Female Date_____
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Birthdate_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Cell Phone_____ Email_____
Whom May We Thank for Referring You?_____
If Student, Name of School / College_____ City_____ State_____ Zip_____
Patient or Parent / Guardian's Employer_____ Work Phone_____
Business Address_____ State_____ Zip_____
Spouse or Parent / Guardian's Name_____ Employer_____ Work Phone_____
Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone_____
Cell Phone_____ Divers License_____
Employer_____ Work Phone_____ ID#_____
Is This Person Currently a Patient in our Office ☐ Yes ☐ No Date of Birth_____
For your convenience we offer the following methods of payment. Please check the option you prefer.
Payment is due at the time services are rendered unless prior arrangements have been made.
☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover
Do you have insurance?_____

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Do you have earaches, neck pains, or regular headaches?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do you wear removable dental appliances?	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐

if yes, explain: _____

How would you describe your current dental concern _____
_____
_____
Date of last dental exam: _____
Date of last dental x-ray: _____
What was done at that time? _____
How do you feel about the appearance of your teeth?
_____

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the last year?	☐	☐
Are you under the care of a physician?	☐	☐

If yes, what is / are the condition (s) being treated?
_____
_____

Date of last physical examination:_____
Physician:_____
Name Phone
Address City / State Zip
Name Phone
Address City / State Zip

	Yes	No
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem? _____
_____
_____

	Yes	No
Are you taking or have you recently taken any medicine(s) including nonprescription medicine?	☐	☐

If yes, what medicine(s) are you taking?
Prescribed:_____
_____
Over the counter:_____
Herbal preparations and / or diet supplements:_____
_____

PLEASE COMPLETE BOTH SIDES

PLEASE CHECK IF YOU HAVE OR HAVE HAD A HISTORY OF THE FOLLOWING:

	Yes		Yes
Do you use tobacco (smoking, sniff, chew)?	☐	Have you had an orthopedic total joint	
If yes, are you interested in stopping?	☐	(hip, knee, elbow, finger) replacement?	☐
Are you allergic to or have you had a reaction to?		If yes, when was the operation done?_____	
Local anesthetics	☐	If you answered yes to the above question, have you had	
Aspirin	☐	any complications or difficulties with your prosthetic joint?_____	
Penicillin or other antibiotics	☐	_____	
Barbiturate, sedatives, or sleeping pills	☐	Has a physician or previous dentist recommended that	
Sulfa drugs	☐	you take antibiotics prior to your dental treatment?	☐
Codeine or other narcotics	☐	If yes, what antibiotic and dose?_____	
Latex	☐	_____	
Iodine	☐	Do you take daily baby aspirin (81mg)?	☐
Hay fever / seasonal	☐	Are you wearing contact lenses?	☐
Keflex_____	☐	**WOMEN ONLY**	
Other (specify)_____	☐	Are you or could you be pregnant?	☐
Metals, Lie, Nickel, Mercury, etc._____	☐	Nursing?	☐
To yes responses, specify type of reaction_____		Taking birth control pills, hormonal replacement, or bone loss medication?	☐
_____			
_____			

PLEASE CHECK A RESPONSE TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

	Yes		Yes
Abnormal bleeding	☐	Hemophilia	☐
AIDS or HIV Infection	☐	Hepatitis, jaundice or liver disease	☐
Anemia	☐	Human Papilloma Virus - HPV	☐
Arthritis	☐	Recurrent infections	☐
Asthma	☐	If yes, indicate type of infection:_____	
Blood transfusion, if yes, date:_____	☐	Kidney problems	☐
Cancer / Chemotherapy / Radiation Treatment	☐	Mental health disorders. If yes, specify:_____	☐
Cardiovascular disease. If yes, specify below:	☐	Malnutrition	☐
___ Angina ___ Heart murmur		Neurological disorders. If yes, specify:_____	☐
___ Arteriosclerosis ___ High blood pressure		Persistent swollen glands in neck	☐
___ Artificial heart valves ___ Low blood pressure		Respiratory problems. If yes, specify below:	☐
___ Congenital heart defects ___ Mitral valve prolapse		___ Emphysema ___ Bronchitis, etc.	
___ Congestive heart failure ___ Pacemaker		Severe headaches / migraines	☐
___ Coronary artery disease ___ Rheumatic heart disease /		Severe or rapid weight loss	☐
___ Damaged heart valves Rheumatic fever		Sinus trouble	☐
___ Heart attack		Sleep disorder - Including Sleep Apnea, Insomnia, and Snoring	☐
Chest pain upon exertion	☐	Sores or ulcers in mouth	☐
Chronic pain	☐	Stroke	☐
Disease, drug, or radiation-induced immuno suppression	☐	Systemic lupus erythematosus	☐
Diabetes, if yes, specify below:	☐	Tuberculosis	☐
___ Type I (insulin dependent) ___ Type II		Thyroid problems	☐
Dry mouth	☐	Ulcers	☐
Eating disorder, if yes, specify: _____	☐	Excessive urination	☐
Epilepsy	☐	Do you have any disease, condition, or problem	☐
Fainting spells or seizures	☐	not listed above that you think I should know about?	
Gastrointestinal disease	☐	Please explain:_____	
G. E. Reflux / persistent heartburn	☐	_____	
Glaucoma	☐	_____	

Consent, Authorization and Release

Consent: I give my consent to the doctor and staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for each treatment. I understand that using anesthetic agents embodies a certain risk.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient (or parent/guardian of minor)

Shirley Ellerbee Cagle, D.D.S., F.A.G.D.

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, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 8, 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 the 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 this Notice, please contact us using the information listed 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 or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: 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 those described in this Notice.

To Your 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 with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 incapacity 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.50 for each page, $75.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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 Communication: 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 payments 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 it 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 (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer Debra Kaul

Telephone: 281-681-9442 Fax: 281-681-9445

E-mail: drcagleoffice@sbcglobal.net

Address: 6769 Lake Woodlands Drive, Suite A, The Woodlands, Texas 77382.

SHIRLEY E. CAGLE , DDS

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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)

Shirley E. Cagle, D.D.S., F.A.G.D.
6769 Lake Woodlands Dr., Suite A
The Woodlands, Texas 77382
Phone: (281) 681-9442

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

Payment arrangements are requested at the time of your visit.
We now offer the following payment options:

__Payment by cash

__Payment by check

__Payment by credit card

__Automatic monthly billing to your Visa or MasterCard

__Guarantee any amount not covered by insurance with Visa or MasterCard

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager.
Thank you.

_____
Print your name here and sign below
X_____
Date: _____