HEALTH HISTORY

Name _____ Date _____

Male/Female Married/Single/Child Date of Birth_____

Social Security #_____

Address_____City/State/Zip_____

HomePhone_____Work_____cell/pager_____

Email Address_____ Employer:_____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No/ Yes If yes, reason:_____

Are you currently receiving care? No/ Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____
5. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

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

1._____ 2. _____
3._____ 4. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a.	Local anesthetics	No	Yes
b.	Penicillin or other antibiotics	No	Yes
c.	Aspirin, Ibuprofen or Tylenol	No	Yes
d.	Codeine, Valium® or other sedatives	No	Yes
e.	Latex or Metals	No	Yes
f.	Other (please specify)_____		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

Do you snore or have you been diagnosed with Sleep Apnea? Yes No

Have you ever had a Sleep Study/testing performed? If yes, please give referring Physician's name and date of sleep study. _____ Yes No
_____

Do you clench or grind your teeth at night? Or, do you wake up with a headache or soreness in facial muscles or jaw joint? Yes No

Have you ever had BOTOX/Dysport or Facial Filler treatments such as Juviderm or Restylane? Yes No

Are you happy with your smile? Yes No
If there was something you could change about your smile, what would it be?
_____
_____

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 or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient/Guarantor (Print Name) *Patient/Guarantor Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*

Dr. Suzanne M. Haley
123 Main St. SSI, GA. 31522
912-638-3559

Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number or each situation.

If your total score is 10 or above, you should think about having a sleep consultation with Dr. Haley.

How likely are you to fall asleep in the following situations?

0=Never
1=Rarely
2=Sometimes
3=Always

Situation	Chance of Dozing
Sitting and Reading	0 1 2 3
Watching television	0 1 2 3
Sitting, inactive, in a public place (theater, meeting)	0 1 2 3
As a passenger in a car for an hour with no break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch, without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3

Total Score: _____

Have you ever had a sleep study? _____
Do you own a CPAP? _____ **If so, do you use it nightly?** _____

Signature:_____ **Date:** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Date of Birth: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS

Purpose of Consent: By signing the 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 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 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:

Contact Person: Sandy Silva, Office Manager

Telephone: 912-638-3559 Fax: 912-638-0360

Address: 123 Main Street, Plantation Village, St. Simons Island, GA 31522

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a 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 consents 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 operations.

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.

Include completed Consent in the patient's chart.

Suzanne M. Haley, D.M.D

123 Main Street, Plantation Village
St. Simons Island, Ga 31522
912 638-3559 Office
912 638-0360 Fax

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as needed. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature _____Date_____

Parent/Responsible party _____

Relationship to patient _____

Social Media/Photo Consent Form

Dr. Suzanne M. Haley and Sleep Golden Isles would like your permission to use images taken of you/your child to showcase before and after smiles, patient testimonies and seasonal promotions on our website, Facebook pages, Instagram and office bulletin board.

Please indicate below the following areas where you consent to the use of your/your child's picture.

Please check all that apply:

____ Office website

____ Sleep Golden Isles Facebook Page

____ Dr. Suzanne Haley DMD Facebook Page

____ Sleep Golden Isles Instagram

____ Office bulletin board

____ I do not consent to my/my child's photo being used on any social media platforms

Declaration

I grant permission for photographs of me/my child to be used in the formats indicated above.

Date ____/____/____

Name of patient:_____

Parent/Guardian Name:_____

Signature of Parent/Guardian:_____

Patient Signature (If over 18 years of age);_____

Dr. Suzanne Haley, DMD, PC

123 Main Street, Plantation Village
St. Simons Island, Ga 31522
912-638-3559 office
912-638-0360 fax
Email: haley.suzanne@comcast.net

24 Hour Appointment Cancellation Policy

The office of Dr. Suzanne Haley has a 24 hour cancellation / rescheduling policy.
If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $50.

This policy is in place out of respect for Dr. Haley and staff as well as our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for the office of Dr. Suzanne Haley DMD as described above.
Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date