

# **Anita B. Youngblood DMD Inc.**

**Cosmetic & General Dentistry**

450 Sutter Street, Suite 1919

San Francisco, California 94108

**Phone: (415) 433-4912**

**Fax: (415) 433-2859 [anita\\_youngblood@yahoo.com](mailto:anita_youngblood@yahoo.com)**

## *Welcome To Our Practice*

We are delighted that you have chosen our office to provide your dental care. To help you feel more comfortable and at home, we have provided you with some information about your first visit to our office.

- We schedule carefully to avoid having you wait. Your time is very valuable to us and we will always treat it with respect.
- Dr. Youngblood will meet with you, one on one to discuss your dental needs and wishes
- A complete oral examination will be given to determine the type of cleaning appropriate for you. We have found that prevention is the key to healthy teeth and gums.
- Diagnostic films will be taken, if needed, on this appointment to evaluate decay, bone loss, and soft and hard tissue lesions.
- Filling out the enclosed paperwork before you arrive in the office will assist in making your visit run as smoothly and quickly as possible.
- If for some reason you cannot keep your reserved time, please give us 24 hours notice so that we can offer the time to another patient. A \$75.00 charge will be applied to any appointment that is cancelled within a 24-hour period.

Our entire team is dedicated to your well being. We are enthusiastic about what dentistry can offer everyone. We are committed to bringing the highest level of care and professionalism possible.

If there are any questions you might have before your reserved time with us, please don't hesitate to call. Thank you again for choosing our office.

Sincerely,

**Dr. Youngblood and Staff**

**Anita B. Youngblood DMD Inc.**

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*Welcome To Our Practice*

**Personal Information**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
                    **First Name                      M.I.                      Family Name                      Nickname**

Referred By: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

**Home Address**

\_\_\_\_\_  
                    **Street                      City                      State                      Zip**

Email Address: \_\_\_\_\_

Home Phone : (\_\_\_\_) \_\_\_\_\_ Work Phone : (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Mobile Number: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you a student? \_\_\_\_\_ If so, what school do you attend? \_\_\_\_\_

Marital Status: \_\_\_\_\_

Who will be responsible for your account? (Check one):

Self     Spouse     Parents     Others: \_\_\_\_\_

Name of Dental Insurance : \_\_\_\_\_

# Health History Form

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>	
<i>Last</i>	<i>First</i>	<i>Middle</i>	( )	( )	( )
Address: _____			City:	State:	Zip:
<i>Mailing address</i>					
Occupation:			Height:	Weight:	Date of Birth:
					Sex:
SS# or Patient ID:	Emergency Contact:		Relationship:	Home Phone: <i>Include area code</i>	Cell Phone: <i>Include area code</i>
				( )	( )

If you are completing this form for another person, what is your relationship to that person?

<i>Your Name</i>	<i>Relationship</i>
_____	_____
<b>Do you have any of the following diseases or problems:</b>	<i>(Check DK if you Don't Know the answer to the the question)</i>
Active Tuberculosis.....	Yes No DK
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes No DK		Yes No DK
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:	
If yes, how often? <i>Circle one: DAILY / WEEKLY / OCCASIONALLY</i>		What was done at that time?	
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes No DK		Yes No DK
Are you now under the care of a physician?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i>	If yes, what was the illness or problem?	
Address/City/State/Zip: _____	( )		
Are you in good health?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has there been any change in your general health within the past year?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
If yes, what condition is being treated?		_____	
Date of last physical exam:		_____	
		_____	

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses?

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: \_\_\_\_\_

**Allergies.** Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. **Yes No DK**

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

**Yes No DK**

Do you use controlled substances (drugs)?

Do you use tobacco (smoking, snuff, chew, bidis)?     
If so, how interested are you in stopping?  
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?

If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_

If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY** Are you:

Pregnant?

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?

Nursing?

**Yes No DK**

Metals \_\_\_\_\_

Latex (rubber) \_\_\_\_\_

Iodine \_\_\_\_\_

Hay fever/seasonal \_\_\_\_\_

Animals \_\_\_\_\_

Food \_\_\_\_\_

Other \_\_\_\_\_

**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

**Yes No DK**

Artificial (prosthetic) heart valve

Previous infective endocarditis

Damaged valves in transplanted heart

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD

Repaired (completely) in last 6 months

Repaired CHD with residual defects

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

**Yes No DK**

Cardiovascular disease

Angina

Arteriosclerosis

Congestive heart failure

Damaged heart valves

Heart attack

Heart murmur

Low blood pressure

High blood pressure

Other congenital heart defects

Arthritis

Mitral valve prolapse

Pacemaker

Rheumatic fever

Rheumatic heart disease

Abnormal bleeding

Anemia

Blood transfusion

If yes, date: \_\_\_\_\_

Hemophilia

AIDS or HIV infection

Arthritis

**Yes No DK**

Autoimmune disease

Rheumatoid arthritis

Systemic lupus erythematosus

Asthma

Bronchitis

Emphysema

Sinus trouble

Tuberculosis

Cancer/Chemotherapy/ Radiation Treatment

Chest pain upon exertion

Chronic pain

Diabetes Type I or II

Eating disorder

Malnutrition

Gastrointestinal disease

G.E. Reflux/persistent heartburn

Ulcers

Thyroid problems

Stroke

Glaucoma

Hepatitis, jaundice or liver disease

Epilepsy

Fainting spells or seizures

Neurological disorders

If yes, specify: \_\_\_\_\_

Sleep disorder

Do you snore?

Mental health disorders

Specify: \_\_\_\_\_

Recurrent Infections

Type of infection: \_\_\_\_\_

Kidney problems

Night sweats

Osteoporosis

Persistent swollen glands in neck

Severe headaches/migraines

Severe or rapid weight loss

Sexually transmitted disease

Excessive urination

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: \_\_\_\_\_

Phone: *Include area code*

( )

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**TMJ Screening History**

**Patient Name** \_\_\_\_\_

**Doctor's Comment**

1. Have you ever had a problem with jaw joints (your TMJs)?  
\_\_\_\_\_

2. Have you ever been injured by a blow to the jaw?  
\_\_\_\_\_

3. Do your jaw joints ever hurt or become tender when you chew or talk?  
\_\_\_\_\_

4. Do you notice any tenderness when you open wide?  
\_\_\_\_\_

5. Do you ever have any clicks, pops or grating sounds in your jaw joints?

6. Did you ever have any clicks or pops?

7. Do you have frequent headaches? Is so, how often? Where?  
\_\_\_\_\_

8. Has your jaw ever locked open? \_\_\_\_\_  
Closed? \_\_\_\_\_

9. Do you ever have difficulty opening?  
\_\_\_\_\_

10. Have you ever been treated for a TMJ problem?  
\_\_\_\_\_

- Bite Splint
- Medication
- Surgery
- Orthodontics
- Physical Therapy
- Equilibrium
- Counseling

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## TREATMENT PLAN

### Please check one:

- I prefer: \_\_\_\_\_ long-lasting solutions \_\_\_\_\_ temporary low-cost solution
- I prefer: \_\_\_\_\_ every detail of my care \_\_\_\_\_ just overall explanation
- I prefer: \_\_\_\_\_ the latest technically-advanced technique  
\_\_\_\_\_ tried and tested method
- I prefer: \_\_\_\_\_ to let my insurance coverage control my care  
\_\_\_\_\_ let my doctor control my care

### Please answer with yes or no, and then explain:

- Do you like the appearance of your teeth? \_\_\_\_\_ your smile? \_\_\_\_\_  
\_\_\_\_\_
- Do you have spaces that you don't like? \_\_\_\_\_  
\_\_\_\_\_
- Do you like the color of your teeth? \_\_\_\_\_  
\_\_\_\_\_
- Do you like the shape of your teeth? \_\_\_\_\_  
\_\_\_\_\_
- Are there old fillings or dental work you don't like looking at? \_\_\_\_\_  
\_\_\_\_\_
- Are there any other concerns that you would like to address with Dr. Youngblood?  
\_\_\_\_\_

**WOMEN NOTE:** *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

Is there any condition concerning your health that the doctor should be told? \_\_\_\_\_

Do you wish to speak to the doctor privately about anything? \_\_\_\_\_

Is there a family history of cancer? \_\_\_\_\_ Diabetes? \_\_\_\_\_ Heart disease? \_\_\_\_\_  
Anesthetic problems? \_\_\_\_\_.

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Tel #: (\_\_\_\_) \_\_\_\_\_. Bus # (\_\_\_\_) \_\_\_\_\_. Is

the visit related to an accident? \_\_\_\_\_ Auto? \_\_\_\_\_ Work related? \_\_\_\_\_ Other? \_\_\_\_\_

Date of Injury \_\_\_\_\_ Ins Co. handling this claim \_\_\_\_\_

Claim #: \_\_\_\_\_

Name of attorney/adjustor \_\_\_\_\_ Tel #: (\_\_\_\_) \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICE**

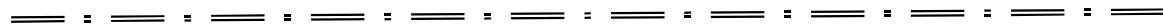
**“You May Refuse To Sign This Acknowledgement”**

I, \_\_\_\_\_ have received a copy of this office’s  
Notice of Privacy Practice.

\_\_\_\_\_  
**Please Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**For Office Use Only**

**We attempted to obtain written acknowledgement of receipt of our "otice of Privacy Practice, but acknowledgment could not be obtained because:**

- Individual refused to sign**
- Communications barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgment**
- Others (Please Specify)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**This form is for educational only, does not constitute legal advice, and covers only Federal, "ot State Law (August 14, 2002)**

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## NOTICE OF PRIVACY PRACTICES

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**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.**

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### 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 \_\_/\_\_/\_\_, 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 anytime. 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.

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### USES AND DISCLOSURES OF HEALTH INFORMATION'

We use and disclose health information about you for treatment, payment, and healthcare operation. 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 Operation:** 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 operation, 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).

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## 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 \$0.\_\_\_\_ for each page, \$\_\_\_\_ 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 told 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.

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## 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 US. 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: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

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This form is educational and does not constitute legal advice, and covers only federal, not state law (August 14, 2002,