sacred circle HEALTHCARE
660 South 200 East #250 · Salt Lake City, UT 84111
Phone: 801-359-2256 · Web: www.sacredcirclehealth.com

HEALTH HISTORY FORM

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.

CONTACT AND PERSONAL INFORMATION

E-mail: _____ Today's Date: _____ SS# or Patient ID: _____

Name: *(Last, First, Middle)* _____ Home Phone: *(Include Area Code)* _____ Bus/Cell Phone: *(Include Area Code)* _____

Address: *(Mailing Address including City, State and ZIP)* _____

Occupation: _____ Marital Status: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M / F

Emergency Contact: *(Name and Relationship)* _____ Home Phone: *(Include Area Code)* _____ Bus/Cell Phone: *(Include Area Code)* _____

If you are completing this form for another person, what is: Your Name: _____ Relationship: _____

How did you hear about us? _____
(Examples: Word of mouth, flyers, friend, advertisement, etc.)

PHYSICIAN INFORMATION

Are you now under the care of a physician? If yes, please complete the physician information below.

Physician Name: _____ Physician Phone: *(Include Area Code)* _____

Physician Address: *(Mailing Address including City, State and ZIP)* _____

PREGNANCY *(Women Only)*

	Y	N	DK
Are you pregnant?	❑	❑	❑
If yes, how many weeks? _____			
Are you taking birth control or hormonal replacement?	❑	❑	❑

EXAMINATION INFORMATION

Please provide the dates for the following;

Date of last physical _____ *Date of last x-rays* _____ *Date of last exam* _____

DRUGS AND ALCOHOL USE

Do you use controlled substance drugs?	❑	❑	❑
If yes, what? _____			
Do you drink alcohol?	❑	❑	❑
If yes, how much in the last 24 hours? _____			
If yes, how much in a week? _____			

TODAY'S VISIT

Please describe the reason for today's visit;

_____
_____
_____
_____

MEDICATIONS AND SUPPLEMENTS

Please list all medications, vitamins, natural or herbal preparations and/or diet supplements you use:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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MEDICAL HISTORY

Please mark (X) your response to indicate if you have or have not had;

	Y	N	DK
Artificial (Prosthetic) Heart Valve	❑	❑	❑
Previous Infective Endocarditis	❑	❑	❑
Atrial Fibrillation	❑	❑	❑
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.			
Are you now under the care of a physician?	❑	❑	❑
Cardiovascular Disease	❑	❑	❑
Angina	❑	❑	❑
High Cholesterol	❑	❑	❑
Congestive Heart Failure	❑	❑	❑
C.O.P.D.	❑	❑	❑
Heart Attack	❑	❑	❑
Heart Murmur	❑	❑	❑
Previous Infective Endocarditis	❑	❑	❑
Low Blood Pressure	❑	❑	❑
High Blood Pressure	❑	❑	❑
Other Congenital Heart Defects	❑	❑	❑
Mitral Valve Prolapse	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic Fever	❑	❑	❑
Blood Clots	❑	❑	❑
Abnormal Bleeding	❑	❑	❑
Anemia	❑	❑	❑
Blood Transfusion *(If yes, what was the date?_____*	❑	❑	❑
Hemophilia	❑	❑	❑
AIDS or HIV Infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune Disease	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Systemic Lupus Erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Persistent cough great than a three week duration	❑	❑	❑
Cough that produced blood	❑	❑	❑
Been exposed to anyone with Tuberculosis	❑	❑	❑
Emphysema	❑	❑	❑

	Y	N	DK
Sinus Trouble	❑	❑	❑
Cancer / Chemotherapy / Radiation Treatment	❑	❑	❑
Chest Pain upon exertion	❑	❑	❑
Chronic Pain	❑	❑	❑
Diabetes – Type I or Type II	❑	❑	❑
Eating Disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑
G.E.R.D. / Heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid Problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Crohn's Disease/Chronic Colitis	❑	❑	❑
Hepatitis, Jaundice or Liver Disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting Spells or Seizures	❑	❑	❑
Neurological Disorders	❑	❑	❑
If yes, specify _____			
Sleep Disorder	❑	❑	❑
Mental Health Disorders	❑	❑	❑
Anxiety	❑	❑	❑
Depression	❑	❑	❑
Recurrent Infections	❑	❑	❑
Kidney Problems	❑	❑	❑
Night Sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent Swollen Glands in Neck	❑	❑	❑
Severe Headaches / Migraines	❑	❑	❑
Severe or Rapid Weight Loss	❑	❑	❑
Gall Bladder Disease	❑	❑	❑
Excessive Urination	❑	❑	❑
Sexually Transmitted Disease (STD)	❑	❑	❑
Enlarged Prostate	❑	❑	❑
Are you taking either of the medications, alendronate (Fosamax®) or ridedronate (Actonel®) for osteoporosis or Paget's Disease?	❑	❑	❑

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? *If yes, what was the date?* _____ ❑ ❑ ❑

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

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

Have you seen any change in your general health during the last year? ❑ ❑ ❑

If yes, what was the illness or problem? _____

ALLERGIES

Are you allergic to;	Y	N	DK
Local Anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other Antibiotics	❑	❑	❑
Barbiturates, Sedatives, or Sleeping Pills	❑	❑	❑
Sulfa Drugs	❑	❑	❑
Codeine or other Narcotics	❑	❑	❑
Metals	❑	❑	❑
Latex (Rubber)	❑	❑	❑
Iodine	❑	❑	❑
Other	❑	❑	❑

If other, what? _____

DENTAL INFORMATION

	Y	N	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets, pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatment?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Are you currently experiencing pain or discomfort?	❑	❑	❑

If so, where? _____

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PROCEDURAL HISTORY

	YEAR		YEAR
Heart Surgery		Heart Surgery	
Appendectomy		Hernia Repair	
Arthroscopic Knee		Hip Replacement	
Back Surgery		Knee Replacement	
Carpal Tunnel Release		Liver Biopsy	
Cataract Surgery		Bone Surgery	
Gallbladder Surgery		Pacemaker	
Colon Surgery		Thyroidectomy	
Gastric Bypass		Tonsillectomy	

FAMILY HISTORY

Has anyone in your immediate family ever had any of the following?

- ❑ *ADD/ADHD*
- ❑ *Alcoholism*
- ❑ *Allergies*
- ❑ *Alzheimer's Disease*
- ❑ *Asthma*
- ❑ *Blood Disease*
- ❑ *Heart Disease*
- ❑ *Cancer*
- ❑ *CVA (Stroke)*
- ❑ *Depression*
- ❑ *Diabetes*
- ❑ *Eczema*
- ❑ *High Blood Pressure*
- ❑ *High Cholesterol*
- ❑ *Learning Disability*
- ❑ *Mental Illness*
- ❑ *Migraines*
- ❑ *Skin Disorders*
- ❑ *Arthritis*
- ❑ *Osteoporosis*
- ❑ *Kidney Disease*
- ❑ *Seizure Disorder*

SOCIAL HISTORY

RACE:
- ❑ White
- ❑ African-American
- ❑ Hispanic
- ❑ Asian
- ❑ Other: _____

LANGUAGE:
- ❑ English
- ❑ Spanish
- ❑ Chinese
- ❑ French
- ❑ Other: _____

ETHNICITY:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

EXERCISE FREQUENCY:
- ❑ 2-3 Times/week
- ❑ 3-4 Times/week
- ❑ Daily
- ❑ Occasionally
- ❑ Never

WHAT IS YOUR TOBACCO USE HISTORY?:

Smoker Status:
- ❑ Current every day smoker
- ❑ Current some day smoker
- ❑ Smoker, current status unknown
- ❑ Never smoker
- ❑ Former smoker
- ❑ Unknown if ever smoked
- ❑ Exposure to second-hand smoke

	Current	Former	Never	Amount/Day	Number of Years
Cigarettes	❑	❑	❑		
Cigar	❑	❑	❑		
Pipe	❑	❑	❑		
Chewing	❑	❑	❑		
Snuff	❑	❑	❑		
Smokeless (Electronic)	❑	❑	❑		

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

I hereby 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/physician 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/physician 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 Physician Date:

OFFICE USE ONLY (Below)

Comments:

HEALTH HISTORY UPDATES: Has your health history changed since these forms were last completed? If no changes, please check this box ❑, then sign and date below.

_____ _____
Signature of Patient/Legal Guardian Date:

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PATIENT CONSENT FORM

Consent to Medical Services

I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood-born infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), if a physician orders such tests for diagnostic purposes.

Assignment of Benefits

This assignment of benefits allows the health care facility and/or facility based physicians to be paid directly by my health insurance carrier or other health benefit plan. In return for the services rendered and to be rendered by the facility and/or facility based physicians all right, title, and interest in all benefits payable for the laboratory services rendered, which provided in any and all insurance policies and health benefit plans form which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the health care facility and/or facility-based physicians an independent right of recovery against my insurer or physicians to pursue any such right of recovery. In no event will the health care facility and/or facility-based physicians retain benefits in excess of the amount owed to the health care facility and/or facility based physicians for the care and treatment rendered during my visit(s).

Payment Agreement

The patient/responsible party or legal guardian obligates him or herself to the payment of practices account incurred in accordance with the regular rates and terms of the practice at the time of discharge. If the patient /responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

Medicare Patient Certification

I certify that the information given by me in applying the payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be sued in place of the original and request payment of authorized benefits be made on my behalf.

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the health care facility and/or facility based physicians.

Patient Name: _____

Signature: *(Patient, legal guardian or authorized agent of patient)* _____ Date: _____

Name: Last _____ First: _____

Date of Birth: _____ /_____ /____

Today's Date: ____ /_____ /_____

Notice of Privacy Practices Acknowledgement

_____ (Patient initials) I acknowledge that I have received Sacred Circle Healthcare Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or concern. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Sacred Circle Healthcare Notice of Privacy Practices.

_____ (Patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

• Healthcare information regarding a prior admission(s) at other healthcare facilities may be made available to subsequent admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

• If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

• Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS.

Patient Name _____ **DOB**_____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Name of Individual & Relation to Patient.	**Date and Initials**

***THE PHYSICIANS/STAFF HAS MY PERMISSION TO:**

Leave message at home with my spouse or NAME:

_____

Leave message on cell phone. Cell phone number: _____
Leave message at work. Work phone number: _____
Leave a message on voicemail. Phone number: _____

_____ _____
Signature of Patient or Legal Guardian **Date**

_____
Printed Name of Patient or Legal Guardian.

Appointment & Financial Guidelines

1. **Welcome to Sacred Circle Health Care** We value our relationship with you and we will provide you with the most modern, high tech and comfortable health care available.
2. Please notify us with any changes in address, phone numbers, email address, marital status, medical situation, medication or insurance coverage ***prior*** to seeing your doctor or provider.
3. Please turn off any cell phones in our office. Cell phones may interfere with our high tech equipment such as lasers, or may cause disruption with others patients in our office.
4. A ***48 business hour*** notice is required to cancel an appointment. If we are given less than a 48 business hour notice, it is considered a ***broken appointment.*** After 2 broken appointments, ***we will not*** be able to schedule you another appointment. We value you as a patient and would still like to see you. However if you want to be seen after 2 broken appointments, you will have to call and see if there is room that day for you to come in and be seen as a walk-in. There may be a wait as we see our regularly scheduled patients first. ***Please make every effort to keep your scheduled appointments.***
5. To prevent inconvenience and to respect our patients time, ***"late" patients"*** (5 minutes past appointment time), may need to be re-scheduled. In order to honor your time, we do not overbook appointments as many offices do. ***Thank you for respecting our relationship by being on time;*** we will strive to do the same.
6. A parent or guardian must sign for children under the age of 18 years old. The parent or guardian that signs the patient in is responsible for that patient's account.
7. ***We do not bill for services.*** We ask that all payments be received ***at the time services are rendered.*** Those who have insurance are responsible for the ***deductible*** and ***co-pay*** at the time of service. We will make our best estimate of your insurance coverage; however you are responsible for knowing the level and extent of your insurance benefits.
8. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your claim in a timely manner (45 days), it will be necessary to charge the account balance to you.
9. You are financially responsible to Sacred Circle Health Care for your account. If your account becomes overdue and/or delinquent, you will need to pay any fees associated with getting your account paid in full.
10. Our goal at Sacred Circle Health Care is to treat you the way you want to be treated. Please let us know ***what matters most to you,*** so we can give you the type of treatment and care that you deserve.

I, _____, agree to the above policy.
(Patient name)

Child's Name (if applicable) _____

_____ Date: _____

Signature *(Patient / Legal Guardian / or authorized agent of patient)*