Medical Health History

Name: _____ Signature: _____ DATE: _____

Do you use a waterpik? YES **How often?** _____

Asthma or Inhalers: YES **What kind?** _____

Food Allergies: Gluten Peanuts Tree Nuts Dairy **Other:** _____

Do you carry an EPI Pen? YES **Drug Allergies?** YES **Antibiotics?** YES **Latex?** YES

Pain meds? YES **Anesthetics?** YES **Other:** _____

TB or Respiratory Disease? YES **Name of medicine:** _____

Cholesterol Medication? YES **Name of medicine:** _____

Blood Pressure Medication? YES **Name of medicine:** _____

Are you on a blood thinner? YES ASPIRIN **Name of medicine:** _____ **INR**____

Do you have a Stent? YES **When was it placed?** _____

Do you have a Pacemaker? YES **When was it placed?** _____

Have you been hospitalized in the last year? YES **When and Why:** _____

Have you had a Joint replaced? YES **When and which one?** _____

Do you need Pre-Med? YES **What is the name of the medicine?** _____

Have you had a stroke? YES **If so when?** _____

Do you have a history of: Fainting? YES **Seizures?** YES **Epilepsy?** YES

Do you have an Autoimmune Disease? YES **How do you treat it?** _____

Do you give blood? YES or NO **Blood transfusion?** YES **When:** _____

Diabetic? YES **If so, which type** _____ **If so, what was your last A1C?** _____

Do you drink alcohol? YES **Do you smoke?** YES

History of drug or alcohol abuse? YES **When and which one?** _____

Hepatitis? YES **If so, which type** _____

STD? YES **If so, which one?** _____

History of a head trauma? YES **If so, when and what?** _____

Do you have migraines or frequent headaches? YES

Do you use nitroglycerin? YES **Do you carry it?** YES

WOMEN:(circle one) NONE **Pregnant** (Weeks_____) Nursing Menopausal Oral contraceptives Hormones

Please list medication not included above_____

DMD _____ **RDH** _____ **DATE** _____ **BP/P**_____

DMD _____ **RDH** _____ **DATE** _____ **BP/P**_____

DMD _____ **RDH** _____ **DATE** _____ **BP/P**_____

DMD _____ **RDH** _____ **DATE** _____ **BP/P**_____

Dr. Ben Sutter

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I (please print name), _____ have received a copy of this offices notice of Privacy Practices.

Signature:_____ **Date:**_____

Additional Party Release *(If Applicable):*

I give consent for Dr. Sutter's office to share information regarding my dental care with the following party: _____

Signature:_____

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 declined

__ Communication barriers prohibited obtaining the acknowledgement

__ Other _____

Effective Date:
February 16, 2026

For Beautiful Smiles

NOTICE OF PRIVACY PRACTICES

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.

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your provider.

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

How We May Use and Disclose Your Information

We may use and disclose health information about you without your permission for the following reasons:

1. **For Treatment:** To coordinate or manage your care with other providers or facilities.
2. **For Payment:** To obtain reimbursement from insurance for services provided.
3. **For Healthcare Operations:** To improve our services, manage our practice, train staff, and perform audits.
4. **For Legal Requirements:** When required by federal, state, or local law.
5. **To Prevent Serious Threats:** To protect your health and safety or the health and safety of others.
6. **For Public Health and Safety:** Including disease prevention, abuse reporting, and FDA oversight.
7. **For Research:** When reviewed and approved under a special process.
8. **For Workers' Compensation and Law Enforcement:** When required under these programs.
9. **With Family or Friends:** If involved in your care and based on your preference or best interest.

We will only share the minimum necessary information needed for each purpose.

We will not use or disclose your health information for marketing, sale, or fundraising without your written authorization. You may revoke this authorization at any time in writing.

Special Protections: Substance Use Disorder (SUD) Records

If your medical record includes information related to substance use disorder treatment protected under federal law (42 CFR Part 2), that information has additional privacy protections:

- We will not disclose it without your written consent unless required by law.
- It may not be used in court or legal proceedings without a special court order.
- You may revoke your consent at any time.
- Any re-disclosure of this information by others may no longer be protected.
- You have the right to opt out of any fundraising communications.

Special Protections Under Oregon Law

Oregon law provides additional privacy protections for certain types of health information. These laws may limit how we use or disclose this information, even when disclosure would otherwise be permitted under federal law (HIPAA).

This includes:

- **HIV/AIDS and HIV testing information** (ORS 433.045), which may not be disclosed without your specific written authorization except as permitted by law.
- **Mental health treatment information** (ORS 179.505–179.509), which may have additional restrictions on use and disclosure.
- **Genetic information** (ORS 192.531–192.549), which is subject to special confidentiality protections.
- **Substance Use Disorder treatment records** protected under federal law (42 CFR Part 2), as described above.

Your Rights

You have the right to:

- **Access**: Ask to see or get a copy of your health and billing records.
- **Amend**: Ask us to correct your records if you think they're incorrect.
- **Request Restrictions**: Ask us not to use or share certain information. We are not required to agree but will consider your request.
- **Request Confidential Communications**: Ask us to contact you in a specific way (e.g., only at work, no voicemail).
- **Accounting of Disclosures**: Ask for a list of when we shared your information for reasons other than treatment, payment, or healthcare operations.
- **Get a Copy of This Notice**: You can request a paper copy at any time.
- **Be Notified of a Breach**: You will be notified if a breach occurs that may have compromised your protected health information.

To exercise any of these rights, contact our Privacy Officer using the details at the bottom of this page.

Our Responsibilities

We are required by law to:

- Keep your health information private.
- Provide you with this Notice.
- Follow the terms of this Notice.
- Notify you if a breach of your protected information occurs.

We may change our privacy practices and update this Notice. If we do, the new terms will apply to all health information we maintain. We will post the updated Notice in our office and on our website, and make copies available upon request.

Complaints and Questions

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact for complaints or more information:	Privacy Officer For Beautiful Smiles 497 Oakway Rd STE 200 Eugene, Or 97401 541-683-7500

We are committed to earning and maintaining your trust by protecting your health information with care and respect.

FOR *Beautiful* SMILES

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 Information

Patient name: _____ **Date of birth:** _____ **Sex:** _____ **Age:** _____

Home address: _____ **City:** _____ **State:** _____ **Zip:** _____

Billing address (if different): _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone:_____ **Cell:**_____ **SS #:** _____ **Driver's license #:** _____ **State:** _____

E-mail: _____ **Employer/Occupation:** _____ **Bus. Phone:** _____

Spouse's name & phone #:_____ **Emergency phone # (other than spouse):** _____

Primary dental insurance: _____ **Group #:** _____

Subscriber's name: _____ **Date of birth:** _____ **$5 #:** _____

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 snore? _____	☐	☐
Do you wear dentures? _____	☐	☐
Do you have Daytime sleepiness? _____	☐	☐
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? _____	☐	☐
Are you in good Health? _____	☐	☐
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 came in contact with:		
Hot foods or liquids? _____	☐	☐
Cold foods or liquids? _____	☐	☐
Sweets? _____	☐	☐
Do you take fluid supplements? _____	☐	☐
Are you dissatisfied with the appearance of your teeth? __	☐	☐
Do you want complete dental care?_____	☐	☐

	YES	NO
Hew often de you brush? _____	☐	☐
Haw 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 heaclaches upon awaking in the morning? _____	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, ar 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? _____	☐	☐