Date:______________________ Chart :____________

Patient Name:_______________________________ DOB:____________ Sex:__Male / Female_____

Address:___________________________ City:_____________ State:____ Zip Code:____________

Home Phone #:______________ Work #:______________EXT______ Cell Phone #:______________

Patient Social Security#:________________ Drivers Lic/ID #:____________ Preffered Name:__________

Email: ___________________________ Marital Status: ___married/divorced/single/widowed____

Responsible Party Name:_______________________ DOB:____________ Sex:__Male / Female_____

Address:___________________________ City:_____________ State:____ Zip Code:____________

Home Phone #:______________ Work #:______________EXT______ Cell Phone #:______________

Social Security#:____________________ Drivers Lic/ID #:__________________

*Relationship to patient:________________________________ Policy Holder: _Y / N_*

How did you hear about our office?:_______________________________

Previous Dentist:____________________ Date of last dental visit:__________/Cleaning:__________

Reason for your visit?:____

Primary Insurance Name:_________________________________ ID #:____________________

Insurance Phone #:______________________Name of Employer:______________________

Insurance Co Address:_____________________ City:_____________ State:____ Zip Code:__________

Name of Insured/Policy Holder/Subscriber:_________________________DOB:______________

Social Security#:____________________Relationship to patient:_______________________

Secondary Insurance Name:_________________________________ ID #:____________________

Insurance Phone #:______________________Name of Employer:______________________

Insurance Co Address:_____________________ City:_____________ State:____ Zip Code:__________

Name of Insured/Policy Holder/Subscriber:_________________________DOB:______________

Social Security#:____________________ Relationship to patient:_______________________

Medical and Dental Health History

Name Last_______________________________ First______________________ **Date of Birth** _____/______/_________

Height __________________ **Weight** ______________ **Sex: M F**

Do you have any of the following diseases or problems:

Active Tuberculosis……………………………………………………………………………………………… Y N
Persistent cough greater than a 3 week duration………………………………………………………… Y N
Cough that produce blood…………………………………………………………………………………… Y N
Been exposed to anyone with tuberculosis……………………………………………………………… Y N

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

Medical information

Joint Replacement: have you had an orthopedic total joint replacement? ……………………………………… Y N

If Yes, Date of the surgery_____________, have you had any complications?___________________________

Are you taking alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease……………… Y N

Were you treated with IV bisphosphonates (Aredia, Zometa) for bone pain, hypocalcaemia, cancer, Paget disease Y N

Do you use tobacco (smoking, snuff, chew)? ……………………………………………………………………… Y N

If yes, How much a day__________________________________

Do you drink alcoholic beverages? …………………………………………………………………………………… Y N

If yes, How much a day__________________________________

Are you allergic to the following (please circle)

Latex……………………………	Y N	Sulfa drugs…………..	Y N	Other____________________________
Aspirin…………………………	Y N	Codeine………………	Y N	____________________________
Penicillin………………………	Y N	Hydrocodone………	Y N	
Barbiturates/sedatives…..	Y N	Metal…………………	Y N	

Mark Yes or No for the following disease or problem

Artificial heart valve………………	Y N	Asthma ……………………………………………	Y N
Infective endocarditits…………..	Y N	GE Reflux/heartburn……………………………	Y N
Congenital heart disease………..	Y N	Hepatitis A/B/C…………………………………	Y N
Heart attack…………………………	Y N	Jaundice or liver disease………………………	Y N
Heart Murmur………………………	Y N	COPD (bronchitis/emphysema)……………….	Y N
Mitral valve prolapsed…………..	Y N	Diabetes Type I or II……………………………	Y N
High blood pressure…………….	Y N	abnormal bleeding………………………………	Y N
Angina………………………………	Y N	Anemia ……………………………………………	Y N
Pace maker…………………………	Y N	Hemophilia………………………………………	Y N
Stroke…………………………………	Y N	Osteoporosis………………………………………	Y N
Arteriosclerosis…………………….	Y N	Kidney problems…………………………………	Y N
Cancer/chemotherapy/radiation…	Y N	AIDS or HIV infection…………………………	Y N
Epilepsy………………………………	Y N	Sexually transmitted disease…………………	Y N
Fainting or seizures………………	Y N	Autoimmune disease……………………………	Y N
Rheumatic fever……………………	Y N	Thyroid problem ……………………………	Y N
Rheumatic heart disease………..	Y N	Mental disorder…………………………………	Y N

Do you have any other medical condition that is not listed above? If so please specify:

____

____

Are you taking any medication? ………………………………………………………………………… Y N

Specify____

____

____

Patient Name_____________________________________

Woman Only

Are you pregnant?........................ Y N

Number of weeks_____________ **Taking birth control pills...... Y N** **Nursing......... Y N**

Dental Health Information

Do you have any tooth pain?.................................... Y N If yes, explain___________________________

Do your gums bleed when you brush or floss?........... Y N

Do you have sleep apnea?.. Y N

Do you brux or grind your teeth?.............................. Y N

Do you snore when you sleep?................................. Y N

Do you have any discomfort in the jaw?.................... Y N

Do you like your smile?.. Y N

Are you planning to whiten your teeth?.................... Y N

Are you seeking any orthodontic (braces) treatment?.. Y N

Have you had any periodontal (gum) treatment?......... Y N

Do you drink fluoride water?... Y N

When was your last dental exam?_______________________________

When was your last professional dental cleaning?_____________________________

What is the reason for your dental visit today?

____

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**______________

Dentist Signature____ **Date**______________

Dentist Notes:

____

____

____ BP________________ Pulse_________

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some change in our office management procedures to make sure we follow the health information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these new rights. We are happy to answer any question you may have.

<u>Control Over Your Health Information</u>

All health care providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver. We must by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine users and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why. Authorizations of non-routine information are one-time –only, case by case, for the use defined by you.

<u>Access to Your Health Information</u>

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get your a copy of your records within 60 days of your request. There may be a cost for this service. Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed. You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

<u>Patient Recourse if Privacy Protections Are Violated</u>

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights. 200 Independence Avenue, SW, Washington, D.C. 20201. If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way. Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries: Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions, or to financial institutions – without your explicit authorization. There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment. Use only the minimum amount of information necessary. In General, use or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

<u>Exceptions</u>

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Out compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

______________________________ __________________________ ____________

Patient/Guardian Signature **Print Name** **Date**