



NOTICE OF PRIVACY POLICIES

Health Insurance Portability and Accountability Act (HIPAA), 1996
<http://www.hhs.gov/ocr/hipaa/finalreg.html>

Name: _____ Phone: _____

Address: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS

You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

Signature

FOR OFFICE USE:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign An emergency situation prevented us from obtaining acknowledgement
 Communications barriers prohibited obtaining the acknowledgement Other (Specify) _____

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

SS #: _____

Birthdate: _____ Age: _____ Male Female Gender Neutral

Home Address: _____
APT/CONDO #:

CITY STATE ZIP

Cell #: _____

E-mail Address: _____

How do you prefer to be contacted? E-Mail Phone Text

Employer: _____

Occupation: _____

Single Married Divorced Widowed Separated

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

How did you find out about us? Friend Google ZocDoc
 Yelp Facebook Other

Whom may we Thank for referring you? _____

INSURANCE COVERAGE

Primary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

SS #: _____ Birthdate: _____

Person Responsible for Account: _____

Cell: _____ Employer: _____

Billing Address: _____

Relation: _____ SS #: _____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: _____ Cell #: _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Your current physical health is: Good Fair Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs?
 Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Herpes / Fever Blisters |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV+ / AIDS |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Hospitalized for Any Reason |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Sickle Cell Disease / Traits |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |

Please list any other drugs/materials that you are allergic to:

DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No Do your gums ever bleed? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No Fresher breath? Yes No

How many times a week do you floss? _____ a day do you brush?

Type of bristles? Soft Medium Hard

Do you smoke or use tobacco in any other form? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date

Signature

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____ Signature

_____ Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

INTERNAL USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____
