

THE DENTAL CARE CENTER
General Family Dentistry

PATIENT INFORMATION:

Name: _____ Sex: M F Preferred Name: _____
 Birthdate _____ Age: _____ S.S.# _____ Marital Status: Single Married Divorced Widowed Child
 Address: _____ City _____ State _____ Zip _____
 Home Phone Number: _____ Work: _____ Cell: _____
 Email: _____
 Is it ok to contact you via (check all that apply) Email Cell Phone Text Message Home Work

PARENT/GUARDIAN INFORMATION:

Person Responsible for Patient (If different from above): _____ Relation to Patient: _____
 Birthdate: _____ S.S.# _____ Phone: _____ Alt.Phone: _____

BILLING INFORMATION:

I do not have Dental Insurance **I have Dental Insurance** Insurance Company _____
 I would like to pay by cash or check at the time of service I would like to pay my estimated portion by cash or check at the time of service
 I would like to pay by credit card at the time of service I would like to pay my estimated portion by credit card at the time of service
 I would like to apply for an extended payment plan I would like to apply for an extended payment plan option

EMERGENCY CONTACT INFORMATION:

Emergency Contact _____ Phone# _____
 Medical Doctor: _____ Phone# _____ Date of last visit: _____

MEDICAL HISTORY:

Have you ever had any serious illnesses or operations? YES NO If yes, please describe: _____
 Have you ever had a blood transfusion? YES NO If yes, please give approximate date: _____
Are you currently taking any blood thinner medications? YES NO
Females: Are you Pregnant? YES NO **Nursing?** YES NO _____ **Taking Birth Control Pills?** YES NO

Please circle any that apply to you:

- AIDS
- ARTHRITIS
- ARTIFICIAL HEART VALVES
- ARTIFICIAL JOINTS
- ASTHMA
- ANXIETY/PANIC ATTACKS
- BACK PROBLEMS
- BLOOD DISEASE
- CANCER
- CHEMICAL DEPENDENCY CHEMOTHERAPY
- CONGESTIVE HEART FAILURE
- DIABETES
- EPILEPSY/SEIZURES
- FAINTING SPELLS
- HEADACHES
- HEART MURMUR
- HEART CONDITION
- BEHAVIORAL PROBLEMS
- HEMOPHILIA

- HEPATITIS: Type _____
- HIGH BLOOD PRESSURE
- HIV POSITIVE
- JAW PAIN
- KIDNEY DISEASE/ DIALYSIS
- MITRAL VALVE PROLAPSE
- OSTEOPOROSIS
- PACEMAKER
- IMPLANTED DEFIBRILLATOR
- RESPIRATORY DISEASE
- RHEUMATIC FEVER
- SCARLET FEVER
- SHORTNESS OF BREATH
- SICKLE CELL DISEASE/ TRAIT
- STROKE
- TONSILLITIS
- TUBERCULOSIS
- VENEREAL DISEASE
- DEVELOPMENTAL PROBLEMS

Please circle any that you are allergic or sensitive to:

- AMOXICILLIN
- ANESTHETICS
- ASPIRIN
- CODEINE
- LATEX
- TYLENOL

OTHER ALLERGIES:

Did you eat prior to the appointment? YES NO

Have you ever taken the drug "Fen-Phen"? YES NO

Please list any medications that you are currently taking: _____

I request and authorize Dental Care Center to examine, clean and provide necessary dental treatment for me/the patient. I further request and authorize the taking of dental x-rays/ photographs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth colored) filling material and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

SIGNATURE: _____

DATE: _____

Regarding HIPAA... We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to make you aware of our privacy practices. By signing below you acknowledge that you have received a copy of our HIPAA guidelines. Thank you.

SIGNATURE: _____

DATE: _____

DENTAL HEALTH:

Date of your last dental visit: ____/____/____

Date of your last dental cleaning: ____/____/____

What is the primary concern that you would like us to address first? _____

Have you ever had serious problems associated with previous dental treatment? Yes No

If so, please explain: _____

What, if anything, happened in a previous dental experience that was a reason to not return? _____

Do you have missing teeth? Yes No

If so, have they been replaced? Yes No

If they have been replaced, are you happy with the result? Yes No

Have you had your wisdom teeth removed? Yes No

Do you feel (or been told) that you do not have fresh breath? Yes No

How many times per day do you brush your teeth? <1 1 2 3 4 more

What type of brush do you use? Soft Medium Hard What brand? _____

How many times per week do you floss your teeth? <1 1 2 3 4 more

Do you use a mouthwash or rinse? Yes No If so, what brand? _____

Do you routinely clean your tongue by brushing or using a tongue scraper? Yes No

Do your gums bleed or become sensitive while brushing or flossing? Yes No

Have you ever been treated for periodontal (gum) disease? Yes No

Do you have areas where your gums have receded? Yes No

Do you currently have pain in any of your teeth? Yes No

Do you have sensitivity to any of the following? Cold Hot Sweets Biting

Are any of your teeth loose? Yes No Which ones? _____

Do you ever have popping, clicking, or pain in you jaw joint? Yes No

Do you have frequent headaches or pain in your neck or shoulders? Yes No

Do you clench or grind your teeth while sleeping or awake? Yes No

If so, do you wear a nightguard or bite appliance? Yes No

Have you ever had orthodontic treatment (braces)? Yes No

If so, do you currently wear a retainer? Yes No

Do you have dental implants? Yes No

If so, when were they placed? _____

Do you ever have sores or ulcers in your mouth? Yes No

Please describe any complications you may have had following previous dental treatment. _____

PHOTOGRAPHIC RELEASE AND CONSENT:

I hereby consent and authorize the Dental Care Center to take photographs, slides, and / or videos of my face, jaws, and teeth. I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used with or without my given name or with a fictitious name for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge The Dental Care Center and its designated representatives from any claim, demands, or liability on account of such use or for the quality of the reproduction of the image.

Signature of Patient or Legal Guardian: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

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.

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 (04/01/2010), 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 any time. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. 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 Operations: 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 operations, 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).

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 practically 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.

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.

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 should 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.

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 U.S. 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: _____