

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ Gender: M F Married: Y N
Work Phone _____ Wireless Phone _____ Wireless Carrier _____
Email _____
Preferred contact method HmPhone WkPhone WirelessPh Email
Preferred contact method for confirmations HmPhone WkPhone WirelessPh Email
Preferred contact method for recall HmPhone WkPhone WirelessPh Email
Student status if dependent over 19 (for ins) Nonstudent Fulltime Parttime
How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family
Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

Comments:



Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____
 Name of Medical Doctor: _____ City/State: _____
 Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

Are you allergic to any of the following?

Y N		Y N		Y N	
<input type="checkbox"/> <input type="checkbox"/>	Anesthetic	<input type="checkbox"/> <input type="checkbox"/>	Iodine	<input type="checkbox"/> <input type="checkbox"/>	Other: _____
<input type="checkbox"/> <input type="checkbox"/>	Aspirin	<input type="checkbox"/> <input type="checkbox"/>	Latex		_____
<input type="checkbox"/> <input type="checkbox"/>	Codeine	<input type="checkbox"/> <input type="checkbox"/>	Penicillin		_____
<input type="checkbox"/> <input type="checkbox"/>	Ibuprofen	<input type="checkbox"/> <input type="checkbox"/>	Sulfa		_____

Do you have any of the following medical conditions?

Y N		Y N		Y N	
<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disease	<input type="checkbox"/> <input type="checkbox"/>	History of Surgery or Hospitalization
<input type="checkbox"/> <input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Sleep Apnea/Snoring
<input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>	Pregnancy	<input type="checkbox"/> <input type="checkbox"/>	Have you ever been told you need antibiotics before dental treatment?
<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Treatment		
<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble		
<input type="checkbox"/> <input type="checkbox"/>	Heart Trouble	<input type="checkbox"/> <input type="checkbox"/>	Stroke		
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Ulcers		
<input type="checkbox"/> <input type="checkbox"/>	Joint Replacement	<input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever		
<input type="checkbox"/> <input type="checkbox"/>	TMJ	<input type="checkbox"/> <input type="checkbox"/>	AIDS/HIV		
<input type="checkbox"/> <input type="checkbox"/>	Cold Sore	<input type="checkbox"/> <input type="checkbox"/>	Other: _____		

Please explain any "Yes" responses: _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: _____

**NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**
[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- *Health Plans* must also:
 - < Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
 - < Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
 - < Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- *Covered Direct Treatment Providers* must also:
 - < Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.

- < When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
 - < In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
 - < Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

[FAQs on Notice of Privacy Practices](#)

[FAQs on ALL Privacy Rule Topics](#)

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Last name: _____ First Name: _____ DOB: _____

X _____ Date: _____