



We are pleased to welcome you into our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_
Last Name First Name Middle Initial
Address \_\_\_\_\_ How long at this address? \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Sex [ ] M [ ] F Age \_\_\_\_\_ Birth date \_\_\_\_\_ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced
Employer \_\_\_\_\_ Number of Years \_\_\_\_\_ Occupation \_\_\_\_\_
Business Phone \_\_\_\_\_
Whom may we thank for referring you? \_\_\_\_\_
Notify in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance

Person Responsible for Account \_\_\_\_\_
Last Name First Name Middle Initial
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Employer \_\_\_\_\_ Occupation \_\_\_\_\_
Business Phone \_\_\_\_\_
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_
Group # \_\_\_\_\_ ID # \_\_\_\_\_

Additional Insurance

Is patient covered by additional insurance? [ ] Yes [ ] No
Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_ Social Security # \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Subscriber's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_
Insurance Email \_\_\_\_\_
Group # \_\_\_\_\_ ID # \_\_\_\_\_

I understand that it is my responsibility to contact my dental insurance company to determine what dental insurance benefits I have available. I understand that as a courtesy Cultural District Dental Care will help me obtain this information and file my claims for dental work performed at their office. I also understand that I am responsible for all expenses not covered by my insurance due at the time of service.

Signature (Parent/Guardian Signature, if minor) \_\_\_\_\_



Dental History

Patient Name: \_\_\_\_\_

Medical Alert: \_\_\_\_\_

We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

Are any of your teeth sensitive to:

- Hot or cold?
Sweets?
Biting or Chewing?
Have you noticed any mouth odors or bad tastes?
Do you frequently get cold sores, blisters or any other oral lesions?

Do your gums bleed or hurt?

- Have your parents experienced gum disease or tooth loss?
Have you noticed any loose teeth or change in your bite?
Does food tend to become caught in between your teeth?
If yes, where?

Do you:

- Clench or grind your teeth while awake or asleep?
Bite your lips or cheeks regularly?
Hold foreign objects with your teeth?
Mouth breathe while awake or asleep?
Have tired jaws, especially in the morning?
Snore or have any other sleep disorders?
Smoke/chew tobacco or use other tobacco products?

Have you ever had:

- Orthodontic treatment?
Oral Surgery?
Periodontal treatment?
Your teeth ground or your bite adjusted?
A bite plate or mouth guard?
A serious injury to the mouth or head?
If so, please describe, including cause

Have you experienced:

- Clicking or popping of the jaw?
Pain? ( joint, ear, side of the face)
Difficulty in opening or closing the mouth?
Difficulty in chewing on either side of the mouth
Headaches, neckaches or shoulder aches?
Sore muscles (neck, shoulders)?

- Are you satisfied with your teeth's appearance?
Would you like to keep all of your teeth all of your life?
Do you feel nervous about having dental treatment?
If so, what is your biggest concern?

Have your ever had an upsetting dental experience?
If yes, please describe

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_



Medical History

Patient Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you... Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If yes, please explain:

Do you have, or have you had, any of the following?

- AIDS/HIV Positive Cortisone Medication Hemophilia Renal Dialysis
Alzheimer's Disease Diabetes Hepatitis A Rheumatic Fever
Anaphylaxis Drug Addiction Hepatitis B or C Rheumatism
Anemia Easily Winded Herpes Scarlet Fever
Angina Emphysema High Blood Pressure Shingles
Arthritis/Gout Epilepsy or Seizures Hives or rash Sickle Cell Disease
Artificial Heart Valve Excessive Bleeding Hypoglycemia Sinus Trouble
Artificial Joint Excessive Thirst Irregular Heartbeat Spina Bifida
Asthma Fainting Spells/Dizziness Kidney Problems Stomach/Intestinal Disease
Blood Disease Frequent Cough Leukemia Stroke
Blood Transfusion Frequent Diarrhea Liver Disease Swelling of Limbs
Breathing Problem Frequent Headaches Low Blood Pressure Thyroid Disease
Bruise Easily Genital Herpes Lung Disease Tonsillitis
Cancer Glaucoma Mitral Valve Prolapse Tuberculosis
Chemotherapy Hay Fever Pain in Jaw Joints Tumors/Growths
Chest Pains Heart Attack/Failure Parathyroid Disease Ulcers
Cold Sores/Fever Blisters Heart Murmur Psychiatric Care Venereal Disease
Congenital Heart Disorder Heart Pace Maker Radiation Treatments Yellow Jaundice
Convulsions Heart Trouble/Disease Recent Weight Loss

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my ( or patient's ) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

# HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other permitted and required uses and disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization** at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. .

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your dentist amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

