

Welcome to our practice!  
This confidential information will help us prepare for your visit.

NAME <input type="radio"/> MRS <input type="radio"/> MR <input type="radio"/> MS <input type="radio"/> REV <input type="radio"/> DR				I PREFER TO BE ADDRESSED AS			
BIRTHDATE				SS #			
ADDRESS				EMAIL			
I AM <input type="radio"/> SINGLE <input type="radio"/> MARRIED <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED <input type="radio"/> SEPARATED				WHOM MAY WE THANK FOR REFERRING YOU?			
HOME PHONE #		CELL PHONE #		WORK PHONE #			
EMPLOYER ADDRESS		EMPLOYER NAME		OCCUPATION			
<p>We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.</p> <p>If you would prefer <b>NOT</b> to receive routine reminders from us via certain methods, please indicate below:</p> <p><input type="checkbox"/> NO TEXT MESSAGES   <input type="checkbox"/> NO EMAILS   <input type="checkbox"/> NO CELL PHONE   <input type="checkbox"/> NO HOME PHONE   <input type="checkbox"/> NO WORK PHONE   <input type="checkbox"/> NO POSTCARDS</p>							
FAMILY MEMBERS SEEN AS PATIENTS HERE							
SPOUSE'S NAME				SPOUSE'S BIRTHDATE			
SPOUSE'S SS#		SPOUSE'S CELL PHONE #		SPOUSE'S WORK PHONE #			
SPOUSE'S EMPLOYER ADDRESS		SPOUSE'S EMPLOYER NAME		SPOUSE'S OCCUPATION			
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE #		EMERGENCY CONTACT RELATIONSHIP			
PERSON FINANCIALLY RESPONSIBLE <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> OTHER	RESPONSIBLE PARTY NAME (IF OTHER)		RESPONSIBLE PARTY PHONE # (IF OTHER)		RESPONSIBLE PARTY SS # (IF OTHER)		
RESPONSIBLE PARTY ADDRESS (IF OTHER)				RESPONSIBLE PARTY RELATIONSHIP (IF OTHER)			
DENTAL INSURANCE COMPANY NAME		DENTAL INSURANCE COMPANY ADDRESS		DENTAL INSURANCE COMPANY PHONE #		GROUP #	
<p>CONCERNS I SEE ABOUT ACHIEVING OR MAINTAINING EXCELLENT DENTAL HEALTH ARE:</p> <p><input type="checkbox"/> I SEE NO OBSTACLES   <input type="checkbox"/> TIME AWAY FROM WORK OR OTHER OBLIGATIONS   <input type="checkbox"/> FEAR BECAUSE OF PAST DENTAL EXPERIENCES</p> <p><input type="checkbox"/> COST OF TREATMENT   <input type="checkbox"/> FEAR OF POSSIBLE DISCOMFORT, PAIN, OR INJECTIONS</p> <p><input type="checkbox"/> OTHER (PLEASE EXPLAIN)</p>							
I BELIEVE MY PRESENT STATE OF DENTAL HEALTH IS <input type="radio"/> POOR <input type="radio"/> FAIR <input type="radio"/> GOOD <input type="radio"/> EXCELLENT				I AM AWARE OF THE CURRENT DENTAL TREATMENT THAT I NEED <input type="radio"/> YES <input type="radio"/> NO			
PLEASE SELECT ONE <input type="radio"/> I AM SATISFIED WITH MY SMILE <input type="radio"/> I AM CURIOUS HOW TO IMPROVE MY SMILE <input type="radio"/> I AM NOT SATISFIED WITH MY SMILE							

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MY CURRENT MEDICAL HEALTH IS <input type="radio"/> EXCELLENT <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> POOR	I AM UNDER THE CARE OF A PHYSICIAN <input type="radio"/> YES <input type="radio"/> NO																																								
PHYSICIAN NAME	PHYSICIAN PHONE #																																								
PHYSICIAN ADDRESS																																									
PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)																																									
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ANEMIA</td> <td><input type="checkbox"/> COLD SORES</td> <td><input type="checkbox"/> FEVER BLISTERS</td> <td><input type="checkbox"/> HIV/AIDS</td> <td><input type="checkbox"/> SCARLET FEVER</td> </tr> <tr> <td><input type="checkbox"/> ARTHRITIS</td> <td><input type="checkbox"/> COLITIS</td> <td><input type="checkbox"/> GLAUCOMA</td> <td><input type="checkbox"/> HOSPITALIZED</td> <td><input type="checkbox"/> SEVERE OR FREQUENT HEADACHES</td> </tr> <tr> <td><input type="checkbox"/> ARTIFICIAL JOINT</td> <td><input type="checkbox"/> DIABETES</td> <td><input type="checkbox"/> HEART ATTACK</td> <td><input type="checkbox"/> KIDNEY PROBLEMS</td> <td><input type="checkbox"/> SHINGLES</td> </tr> <tr> <td><input type="checkbox"/> ARTIFICIAL VALVE</td> <td><input type="checkbox"/> DIFFICULTY BREATHING</td> <td><input type="checkbox"/> HEART MURMUR</td> <td><input type="checkbox"/> MITRAL VALVE PROLAPSE</td> <td><input type="checkbox"/> SINUS PROBLEMS</td> </tr> <tr> <td><input type="checkbox"/> ASTHMA</td> <td><input type="checkbox"/> DRUG/ALCOHOL DEPENDENCE</td> <td><input type="checkbox"/> HEART SURGERY</td> <td><input type="checkbox"/> PACEMAKER</td> <td><input type="checkbox"/> STROKE</td> </tr> <tr> <td><input type="checkbox"/> BLOOD TRANSFUSION</td> <td><input type="checkbox"/> EMPHYSEMA</td> <td><input type="checkbox"/> HEMOPHILIA/BLEEDING</td> <td><input type="checkbox"/> PSYCHIATRIC PROBLEMS</td> <td><input type="checkbox"/> TUBERCULOSIS</td> </tr> <tr> <td><input type="checkbox"/> CANCER</td> <td><input type="checkbox"/> EPILEPSY/SEIZURES</td> <td><input type="checkbox"/> HEPATITIS</td> <td><input type="checkbox"/> RADIATION TREATMENT</td> <td><input type="checkbox"/> ULCERS</td> </tr> <tr> <td><input type="checkbox"/> CHEMOTHERAPY</td> <td><input type="checkbox"/> FAINTING</td> <td><input type="checkbox"/> HIGH/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/> RHEUMATIC FEVER</td> <td><input type="checkbox"/> VENEREAL DISEASE</td> </tr> </table>		<input type="checkbox"/> ANEMIA	<input type="checkbox"/> COLD SORES	<input type="checkbox"/> FEVER BLISTERS	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> SCARLET FEVER	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> COLITIS	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> HOSPITALIZED	<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> ARTIFICIAL JOINT	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> ARTIFICIAL VALVE	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DRUG/ALCOHOL DEPENDENCE	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> STROKE	<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> HEMOPHILIA/BLEEDING	<input type="checkbox"/> PSYCHIATRIC PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RADIATION TREATMENT	<input type="checkbox"/> ULCERS	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> FAINTING	<input type="checkbox"/> HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> VENEREAL DISEASE
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PLEASE CHECK ANY OF THE FOLLOWING DRUGS YOU HAVE USED AT ANY TIME <input type="checkbox"/> ACTONEL <input type="checkbox"/> AREDIA <input type="checkbox"/> BIOPHOSPHONATES/BISPHOSPHONATES <input type="checkbox"/> BONIVA <input type="checkbox"/> DIDRONEL <input type="checkbox"/> FOSAMAX <input type="checkbox"/> SKELID <input type="checkbox"/> ZOMETA																																									
ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> DENTAL ANESTHETIC <input type="checkbox"/> ERYTHROMYCIN <input type="checkbox"/> LATEX <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA <input type="checkbox"/> TETRACYCLINE <input type="checkbox"/> OTHER (PLEASE LIST): _____																																									
WOMEN ONLY ARE YOU PREGNANT? <input type="radio"/> YES <input type="radio"/> NO              ARE YOU NURSING? <input type="radio"/> YES <input type="radio"/> NO              ARE YOU TAKING BIRTH CONTROL? <input type="radio"/> YES <input type="radio"/> NO																																									
PLEASE SELECT ONE <input type="radio"/> I CURRENTLY HAVE NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY <input type="radio"/> I CURRENTLY HAVE SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY																																									
PLEASE SELECT ONE <input type="radio"/> MY MOUTH IS VERY COMFORTABLE <input type="radio"/> MY MOUTH IS MODERATELY COMFORTABLE <input type="radio"/> MY MOUTH IS UNCOMFORTABLE																																									
<p>The information provided is accurate &amp; complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.</p> <p>I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.</p>																																									
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE																																								

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DATE OF LAST DENTAL VISIT		DATE OF LAST DENTAL CLEANING		DATE OF LAST FULL MOUTH X-RAYS	
PREVIOUS DENTIST NAME			PREVIOUS DENTIST PHONE		
PREVIOUS DENTIST STREET ADDRESS			CITY	STATE	ZIP CODE
HOW OFTEN DO YOU BRUSH YOUR TEETH?	HOW OFTEN DO YOU FLOSS?		WHAT OTHER DENTAL AIDS DO YOU USE? (SONICARE, WATERPIK, ETC.)		
DO YOU HAVE ANY DENTAL PROBLEMS NOW? <input type="radio"/> YES <input type="radio"/> NO		IF YES, PLEASE DESCRIBE:			
<p>PAST DENTAL TREATMENT (SELECT ALL THAT APPLY)</p> <input type="checkbox"/> HAD ORTHODONTIC TREATMENT (BRACES) <input type="checkbox"/> HAD ORAL SURGERY (TYPE _____) <input type="checkbox"/> BEEN DIAGNOSED WITH OR TREATED FOR PERIODONTAL (GUM) DISEASE <input type="checkbox"/> DIAGNOSED OR TREATED FOR ORAL CANCER <input type="checkbox"/> WEAR ANY REMOVABLE DENTAL APPLIANCES (MOUTHGUARD, PARTIALS, DENTURES, RETAINERS)					
<p>DENTAL CONDITIONS (SELECT ALL THAT APPLY)</p> <input type="checkbox"/> TEETH SENSITIVE TO HOT / COLD / BITING / SWEETS <input type="checkbox"/> JAW CLICKING OR POPPING (WITH / WITHOUT PAIN) <input type="checkbox"/> TIRED JAW <input type="checkbox"/> CHRONIC HEAD / NECK / EAR ACHES <input type="checkbox"/> MUSCLE PAIN IN FACE OR NECK <input type="checkbox"/> FEEL YOU HAVE CHRONIC BAD BREATH <input type="checkbox"/> GUMS BLEEDING OR HURTING <input type="checkbox"/> FOOD ALWAYS CATCHING IN TEETH <input type="checkbox"/> MOUTH BREATHE WHILE ASLEEP OR AWAKE <input type="checkbox"/> FEEL LIKE YOUR MOUTH IS ALWAYS DRY <input type="checkbox"/> HAVE RECURRENT CANKER SORES (INSIDE MOUTH) <input type="checkbox"/> HAVE RECURRENT COLD SORES (OUTSIDE MOUTH) <input type="checkbox"/> BITE/CHEW YOUR LIPS OR CHEEKS REGULARLY					
<p>I have reviewed this questionnaire and answered its questions accurately and to the best of my knowledge. I understand that the answers I have provided will be used by the doctor to determine appropriate dental treatment. I agree to notify the practice if any health changes occur. I authorize the doctor and dental staff to perform the necessary dental services. I authorize the dental staff to release all information necessary to secure payment of benefits. I authorize my insurance company to pay the doctor directly. I authorize the use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that I am financially responsible for any charges not covered by my dental insurance.</p>					
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY				DATE	

**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 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).

**THIS NOTICE OF PRIVACY PRACTICES CONTINUES ON NEXT PAGE**

## 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 practicably 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, charges may apply for printing, postage, and time needed to complete the request. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**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. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**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 Website 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 file your complaint 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.

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*Note: You may refuse to sign this acknowledgment.*

I, _____ have received a copy of this office's Notice of Privacy Practices.	
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

## FOR OFFICE USE ONLY

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

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- OTHER (PLEASE SPECIFY): \_\_\_\_\_

SIGNATURE OF OFFICE REPRESENTATIVE	DATE
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