Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

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

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Wk #: (____)_____ Date of last visit: _____

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

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

Please list each one: _____

_____

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

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If so, when? _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

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

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

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

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

_____

5 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

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

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

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

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

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.

_____

Signature Date

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

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

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

Documentation of HIPAA Security Implementation Standards

The HIPAA Privacy regulations required the adoption of formal policies and procedures. For the HIPAA Security Standards, the documentation is even more important. Clinical practices must assess their need to comply with an addressable or required standard, implement an alternative measure, or not implement any measure at all as long as the practice will still meet the security standard to which it applies. The rationale behind such decisions must be adequately documented.

To assist our insureds in this process, what follows is an example of documentation of a security decision. In this example, our fictitious practice, Dental Practice Group (DPG) has looked at an addressable implementation specification under the transmission security standard. The standard requires the practice to "implement technical security measures to guard against unauthorized access to EPHI transmitted over an electronic communications network."

DPG has looked at the addressable implementation specification of encryption. They assessed the situation and ultimately decided not to use encryption to address the security standard. Here is the documentation they used to back up their decision.

SAMPLE POLICY

Current State Assessment Criteria

To ensure:

1. That EPHI that is transmitted electronically is not vulnerable to interception; and

2. That DPG's policies and procedure address HIPAA security requirements.

Current State Security Assessment

Readily available network access to claims information by clearinghouses is a benefit to DPG as well as its business associates. It promotes good business relations and services as a cost-efficient tool that allows DPG's staff to access information more quickly and efficiently.

The following gaps in security have been observed:

- There is no organization-wide policy governing access to PHI by health care clearinghouses. Sometimes information is e-mailed to other organizations, other times the organizations are given access to the private network containing EPHI and claims information;
- E-mail transmissions of EPHI over the Internet to clearinghouses are not protected, and could be intercepted by unauthorized users.

Risk Assessment

The risk of interception of claims information by unauthorized users over an open network is high, and the consequences of such interception are substantial. E-mail transmissions may be intercepted, allowing others to gain access to EPHI. DPG has no way of knowing whether e-mail transmissions have been intercepted and access to EPHI has been acquired. Intercepted information substantially increases the risk of wrongful disclosure of patient health information. Improperly secured information can subject DPG to penalties, possible civil and/or criminal action, including imprisonment, and irreparable harm to its reputation.

Options and Consequences

Option #1 (Implementation Specification):
Encrypt all information made available to clearinghouses. Consequence: Information is protected it if is intercepted, but computer response time is slowed considerably as a result of each piece of information that needs to be encrypted.

Option #2 (Alternative)
Limit electronic communications involving EPHI to the existing Web link for each clearinghouse, which permits unencrypted information to flow only to that organization. Clearinghouses will be given authentication codes to ensure that they are entitled to access and receive information. Consequence: Unauthorized third parties will not have access to information if it is intercepted, and computer systems remain at optimum speed.

Decision

To comply with HIPAA and protect the security of EPHI, DPG must implement technical policies and procedures for electronic information system that maintain EPHI to allow access only to those persons or software programs that have been granted access rights.

DPG has decided to adopt Option #2 as an alternative to the implementation specification in the HIPAA security regulations that suggests encryption as a method of access control. Option #2 establishes reasonable and appropriate measures and demonstrates the commitment of DPG to protect against unauthorized access to EPHI. This option allows access of EPHI only to those organizations that are authorized to receive it and allows DPG to meet its obligation to keep EPHI secure.

Encrypting the information as outlined in Option #1 is not reasonable or appropriate. The slowed computer time would inhibit DPG to operate at an effective level. Encryption outlined in Option #1 would provide a higher degree of protection from unauthorized access to EPHI, however, such instances of unauthorized access are unlikely to occur, and Option #1 would therefore be excessive. The small likelihood of unauthorized access would not justify the negative business effects associated with encryption.

CONSENT FOR ORAL CONSCIOUS SEDATION

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have chosen **oral conscious sedation** for your treatment. You have the right to be informed about this so that you can decide whether to have it or not after knowing the risks and benefits. These common procedures are considered quite safe. Nevertheless, all procedures have some risks. They include the following and others:

_____1. Allergic reactions (previously unknown) to any of the medications used.

_____2. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be required for relief.

____ 3. Oral conscious sedation is a serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

YOUR OBLIGATIONS:

_____4. Because anesthetic or sedative medications (including oral premedication) causes drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until you are recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

_____5. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

_____6. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK for **six (6) hours** prior to your treatment. TO DO OTHERWISE MAY BE LIFE-THREATENING.

_____7. **Unless instructed otherwise**, it is important that I discuss which regular medications (high blood pressure, antibiotics, etc.) I should take prior to my oral conscious sedation. **If instructed to take medications, take using only a small sip of water**.

CONSENT

I have read and understand the above paragraphs and realize that conscious sedation has certain serious risks. I request that my choice be used for my treatment. I fully understand the risks involved. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date