Advanced Dental Implant Solutions

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 (DENTAL)

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 West7th Smiles 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?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleep disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or your bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause_____		
_____		

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of the face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficultly in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		
_____		
Have you ever had an upsetting dental experience?	Yes	No
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? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

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

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 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 require by law.

Treatment: we will use and disclose your protect 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 health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information to 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 remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation 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 might 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 record, 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 is not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friend who may be involved on your care or for notification purpose as describes in this Noticed 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 nay request. If dentist believes it is in 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 filling 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 protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number

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

Print Name _____

Signature _____

Date: _____