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 ID #: _____

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 ID #: _____

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 supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

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

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ 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)

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

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

_____

_____

Are you allergic to any of the following?

Aspirin	Erythromycin	Penicillin
Codeine	Jewelry / Metals	Tetracycline
Dental Anesthetics	Latex	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? ☐ Soft ☐ Medium ☐ Hard

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: _____

_____

_____

ANNUAL HISTORY UPDATE

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____

Notices of Privacy Practices

Interstate Dental Clinic
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Portland, Oregon 97217
503-285-5307 (o)
503-285-3463 (f)
drward@teleport.com

Notices of Privacy Practices (NPPs)

Providers and health plans will likely need to update their Notices of Privacy Practices (NPPs). The updated NPPs must advise individuals of the Omnibus Rule's required changes, specifically including, as applicable:

1. The prohibition on the sale of PHI without the express written authorization of the individual;
2. The duty of a CE to notify affected individuals of a breach of unsecured PHI;
3. The individual's right to opt out of receiving any fundraising communications from the CE; and,
4. The right of the individual to restrict disclosures of PHI to a health plan with respect to health care for which the individual (or their family or friends) has paid out-of-pocket and in full.

<u>All covered entities must include the following in their NPPs:</u>

- ❑ A statement that the following uses and disclosures will be made only with authorization from the individual:
  - o uses and disclosures for marketing purposes;
  - o uses and disclosures that constitute the sale of PHI;
  - o most uses and disclosures of psychotherapy notes (if CE maintains them); and,
  - o other uses and disclosures not described in the notice

- ❑ A statement that the CE is required by law to notify affected individuals following a breach of unsecured PHI. This statement may be general in nature and is not required to provide detailed information about what constitutes a breach or what notices are required.

- ❑ If a CE intends to contact an individual for fundraising purposes, a statement of such intent and the individual's right to opt out of receiving fundraising communications.

- ❑ Notice of the right to opt out of fundraising communications (if the covered entity conducts fundraising).

- ❑ A description of the types of uses and disclosures that require an authorization under § 164.508(a)(2)(a)(4). These include most uses or disclosures of psychotherapy notes, marketing communications and sales of PHI. The NPP also must state that other uses and disclosures not described in the notice will be made only with the individual's written authorization.

Health care providers must include in their NPPs a statement about an individual's right to restrict disclosures of protected health information to health plans if an individual has paid for services out of pocket in full.

Health plans (except for long-term care plans) must include in their NPPs a statement that the health plan is prohibited from using or disclosing genetic information for underwriting purposes.

The previously required statement that the a CE may contact an individual with appointment reminders or information about treatment alternatives or other health-related benefits or services, at the option of the covered entity, may be *deleted* from the notice.

CEs also will want to review their NPPs to ensure that they accurately describe their privacy practices, especially in light of the Omnibus Rule's new requirements.

Distribution of Revised NPPs – Different for Providers versus Health Plans
The requirements for distributing updated NPPs have been modified for health plans but *not* for health care providers. Health plans may include their revised NPP in their next annual mailing as long as they prominently post the revised NPP on their web sites by the effective date of the material change to the NPP. Health plans that do not have customer service web sites are required to provide the revised NPP, or information about the material change and how to obtain the revised notice, to individuals covered by the plan within 60 days of the material revision to the NPP.

Health Care Providers – The revised NPP must be available to existing patients upon request, and must be posted both to the provider's website (if they have a website) and in a prominent location on the premises. New patients must be provided with a copy of the revised NPP.

Health Plans – The revised NPP must either (1.) be posted to the health plan's website and all members notified of the revisions in the next annual mailing, or (2.) if it is not posted to a website, the revised NPP, or information about the material changes and how to obtain the revised notice, must be distributed to all members within 60 days of the revisions.

I acknowledge that I have read the above and understand I may request a detailed version of privacy practices at the Interstate Dental Clinic.

Patient signature_____

Patient Printed Name_____

Date_____