

# DENTAL HEALTH HISTORY

**CONFIDENTIAL**

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Preferred name \_\_\_\_\_ Birth date \_\_\_\_\_

SSN \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_

Email \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Policyholder Name \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

ID Number \_\_\_\_\_ Policyholder's birth date \_\_\_\_\_

Policyholder's SSN \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Check ( ✓ ) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Dry mouth/ Xerostomia          |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot/cold        | <input type="checkbox"/> Sores or growths in your mouth |

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

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include Fosamax, Boniva, Prolia and Zometa? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Check ( ✓ ) if you have or have had any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Scarlet Fever                 |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Skin Rash                     |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain            | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy/Seizures    | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Swelling of Feet or Ankles    |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problems              |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Tobacco Habit                 |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tonsillitis                   |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur/MVP     | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer                         |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Venereal Disease/Herpes Virus |

## MEDICATIONS

## ALLERGIES

List medications you are currently taking: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone # \_\_\_\_\_

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Sulfa      |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Latex      |
| <input type="checkbox"/> Local Anesthetic              | <input type="checkbox"/> Other      |

## SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

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## HIPAA -Authorization to Release Information

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Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

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I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
Relationship

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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I understand that if my personal health information (phi) is required to be transferred via email or in any capacity, said email **will not be encrypted** by Germantown Dental Care and I do not hold Germantown Dental Care accountable for potential loss or misuse of my phi.

\_\_\_\_\_ I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_ I refused to receive a copy

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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### For Office Use Only

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

- ☐ Individual refused to sign
  - ☐ Communications barriers prohibited obtaining the acknowledgement
  - ☐ An emergency situation prevented us from obtaining acknowledgement
  - ☐ Other (Please Specify)
-

# Germantown Dental Care

## Office Policy and Financial Agreement

+ behind our treatment only when the patient is seen on a regular basis and is under our regular care every six months or as recommended by the doctor.

I hereby authorize Germantown Dental Care to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regards to my insurance coverage is correct. I further authorize the release of any information, including medical and dental information for this or any related claim to my insurance carrier. Once insurance maximum benefits have been reached, we reserve the right to charge procedures at our usual customary and reasonable fees previously set by the corporation. Patients agree and understand that Germantown Dental Care estimate fees to the best of our ability and is never a guarantee of benefits and upon review by the insurance companies contracted charges could change without notice. No refunds will be given until all claims have been paid by the insurance company. Refunds may take up to 90 days to process.

I understand and agree that I am financially responsible for charges not paid by my insurance company. Charges not paid within 90 days by insurance company will be made "*patient responsible*". I further agree in the event of non-payment, to be responsible for the cost of collections, and or court costs and any reasonable legal fees. Refunds may take up to 90 days to process.

At Germantown Dental Care, it is the policy that, any work that will require an hour appointment and/or may cost more than \$500.00 will require a deposit of 50% of treatment total cost to reserve your appointment and the balance due day of prior to appointment. As well as, in the event of no call no show and cancellation under 24 hours, there is a \$50.00 fee for cleaning appointment and \$100 for scheduled doctor appointments.

In an effort to make sure all Germantown Dental Care patients, as well as staff, are treated with courtesy and respect, I hereby understand and agree in the event I arrive 15 minutes late to my appointment, Germantown Dental Care has the right to reschedule my appointment when there is availability.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

# HIPAA Notice of Privacy Practices

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

## About This Notice

This notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations 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 condition, or mental health or condition, as well as services related to health care.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information received in the future. You can obtain any revised notice of privacy practices by contacting our office.

## How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes: However, our office may have a reason to make some of these disclosures.

### *For Treatment*

We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment.

### *For Payment*

Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for legal necessity, and undertaking utilization review activities. For example, in order to obtain approval for a hospital stay, your relevant protected health information may need to be disclosed to your health plan.

### *For healthcare operations*

We may use and disclose your protected health information for health care operation purposes only. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operational and management purposes. For example, we may use your protected health information to review the treatment and services you receive and to check on the performance of our caring staff. We may also disclose information to doctors, nurses, technologists, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice may also share information with each other for the purposes of joint healthcare operations.

### *Appointment Reminders/Treatment Alternatives/Health Related Benefits and Services*

We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives, or health-related benefits and services that may be of interest to you.

### *Fundraising Activities*

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, to contact you for fundraising activities supported by our office. If you do want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

### *Plan Sponsors*

If your coverage is through an employer-sponsored group health plan, we may share protected health information with your plan sponsor.

### *Facility Directories*

Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people.

For you by name, members of the clergy will be told your religious affiliation. You have the option of agreeing to or objecting to the use or disclosure of all or a portion of your protected health information. If you are unable to agree or object to the use or disclosure of protected health information, your doctor may use professional judgment to determine whether the disclosure is in your best interests. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

### *Others Involved in Your Healthcare*

Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional

Judgment We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to a government or private entity authorized to assist in disaster relief efforts, as well as to coordinate uses and disclosures to family members or other individuals involved in your healthcare.

### *Required by law*

use or disclose your protected health information to the extent that the use or disclosure is required by law. use or disclosure

will be made in violation of the law and will be limited to the relevant legal requirements. You will be notified, as required by law, of any such uses or disclosures.

### *Public Health*

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information to a foreign government agency that is collaborating with the public health authority if directed by the public health authority.

### *Business Associates*

We may disclose your protected health information to our business associates that perform functions on our behalf.

services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

### *Communicable Diseases*

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

### *Health Oversight*

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil rights laws.

## **Abuse or Neglect**

We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of fraud.

neglect or domestic violence to a governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal law.

## ***Food and Drug Administration***

We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product re-calls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

## ***Legal Proceedings***

We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to subpoena, discovery request or other lawful process.

## ***Law Enforcement***

We may also disclose your protected health information, ~~solong as applicable legal requirements are met, for law enforcement purposes.~~ These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

## ***Coroners, Funeral Directors, and Organ Donation***

We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or issued on at ion purpose

## ***Research***

We may disclose your protected health information to researchers when the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

## ***Criminal Activity***

Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

## ***Military Activity and National Security***

When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary *by* appropriate military command authorities; (2) for the purpose of a determination *by* the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services, We *may* also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

## ***Workers' Compensation***

Your protected health information may be disclosed *by* us as authorized. to comply with workers' compensation laws and other similar legally established programs.

## ***Inmates***

We *may* use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

## ***For Data Breach Notification Purposes***

We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of

your plan, if applicable, through which you receive coverage.

### ***Required Uses and Disclosures***

Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500et.seq.

#### **Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

#### **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization**

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

#### **Your Rights Regarding Health Information About You**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office use for making decisions about you. 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 must make a written request to inspect and copy your design at defile. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

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 health care 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.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

**You have the right to restrict information given to your third-party payer if you fully pay for the services out of your pocket.** If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third-party payer since no claim is being made against the third-party payer.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this

request in writing to our office.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 please contact our office if you have questions about amending your medical record. Your request must 'be in writing and provide the reasons for the requested amendment.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

**You have the right to obtain paper copy of this notice from us, upon** request, even if you have agreed to accept this notice electronically.

**You have the right to receive notice of a security breach. We are required to notify you if your architected health information has been breached.** The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

#### **Complaints or Questions:**

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate