LAKEWOOD PERIODONTICS

PATIENT REGISTRATION

Patient's name _____ Birth date _____

Name of spouse/partner _____ Birth date _____

If a child, parent's name _____

Street address _____ Phone _____

City _____ State _____ Zip _____

Patient employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Spouse/partner employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Purpose of this appointment _____

In case of emergency, who should be notified _____ Phone _____

Person responsible for this account _____

Social Security number _____

_____

Spouse/partner's Social Security number _____

_____

_____ _____ _____

_____ _____

If you have insurance, name of insured _____

Name of insurance company _____ Policy no. _____

If spouse/partner has insurance, name of insured _____

Name of insurance company _____ Policy no. _____

Whom may we thank for referring you _____

Your Signature _____ **Date** _____

Comments: _____

Single ☐
Widowed ☐
Married ☐
Long Term Partner ☐
Divorced ☐
Separated ☐

LAKEWOOD PERIODONTICS

HEALTH HISTORY

Name _____

1. Have you seen a physician within the past two years? _____
   If yes, for what problem _____
2. Name and address of your regular physician.

   _____
3. Have you been a patient in the hospital within the past two years? _____
   If yes, for what problem _____
4. Circle any of the following that you have had or presently have:

Heart failure	Chronic cough	Hepatitis
Heart disease or attack	TB	Liver disease
Angina pectoris	Asthma	Yellow jaundice
High blood pressure	Hay fever	Blood transfusion
Heart murmur	Sinus trouble	Drug addiction
Congenital heart lesions	Diabetes	Hemophilia
Artificial heart valve	Thyroid disease	Venereal disease
Heart pacemaker	Genital herpes	Heart surgery
Chemotherapy	Cold sores/fever blisters	Anemia
Arthritis	Epilepsy	Stroke
Cortisone medicine	Fainting or dizziness	Kidney trouble
Glaucoma	Nervousness	Ulcers
AIDS	Psychiatric treatment	Emphysema
Sickle cell disease	Enlarged lymph nodes	

5. Have you ever had any operations or surgery? _____
   If yes, for what problem _____
6. Have you ever had excessive bleeding requiring special treatment? _____
7. Are you taking any medicines, drugs or pills of any kind? _____
   If yes, what kind _____
8. Do you have any allergies to drugs or medicines? _____
   If yes, to what and how do you react? _____
9. Have you ever had an unusual reaction to a dental anesthetic? _____
10. Have you intentionally lost or gained more than 10 pounds in the last year? _____
11. Are you on a special diet? _____
12. Has your medical doctor ever said you have a cancer or tumor? _____
13. Do you have any disease, condition or problem not listed? _____
14. WOMEN: Are you pregnant? _____ Are you practicing birth control? _____
    Do you anticipate becoming pregnant? _____

DATE: _____ SIGNATURE: _____

LAKEWOOD PERIODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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)

_____

_____

_____

Clifford Thomas D.D.S., M.S..

NOTICE OF PRIVACY PRACTICES

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 takes effect (04/07/03), and 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

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 complain to us 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.