NEW PATIENT INFORMATION FOR COMPUTER

LAST NAME	FIRST NAME	MI			
ADDRESS					
CITY	STATEZIP				
HOME PHONE #	WORK PHONE #				
CELL PHONE #	E-MAIL				
SS#	D.O.B				
REFERRING DOCTOR					
DENT	AL INSURANCE INFORMATION				
PLEASE NOTE:	We do not accept Medicare or Medica	id insurance.			
PRIMARY INSURED'S NAME					
SS#	D.O.B				
EMPLOYER					
DENTAL INSURANCE COMP	ANY				
ADDRESS					
PHONE #	GROUP #	ID#			
RELATIONSHIP TO PATIENT					
SECONDARY INSURED'S NA	ME				
SS#	D.O.B				
EMPLOYER					
DENTAL INSURANCE COM	PANY				
ADDRESS					
PHONE #	GROUP #	ID#			
RELATIONSHIP TO PATIEN	Γ	: CC			

07/29/10

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Drug	Reaction	one/A	larging
Diuu	neacti	JIIO/M	ilei ules

MEDICAL HISTORY FORM

LAST	NAME	FIRST	M.I.	BIRTHDAT	E	HEIGHT	WEIGHT	MARITAL STATU	JS
НОМ	E ADDRESS		CITY		STA	ATE .	ZIP	HOME TELEPHON	NE
EMPL	OYER	OCCUPATI	ON		SC	CIAL SECURITY #		BUSINESS TELEPHON	NE
NAMI	E OF HUSBAND, WIFE of	r PARENT	DENTAL IN	SURANCE				CELL PHON	NE
REFE	RRED BY	NAME OF DE	ENTIST		NAME	OF PHYSICIAN			
					TELEF	PHONE			
1. Hav	ve you had any serious illepitalized in the past 5 years	ness, operation, or bars?	een	Yes No	8.	Have you had abno a. Have you ever r	ormal bleeding? required a blood tr	Yes ransfusion? Yes	No No
	there been any change lith within the past year?			Yes No				as anemia?Yes tumor or growth?Yes	No No
	last physical examination				11.	Have you ever had	radiation or chemi	otherapy	
4. Are	you now under the care o, what is the condition be	of a physician eing treated?		Yes No	12.	Are you allergic or h	have you had a rea		No
_						a. Local anesthetic	CS	Yes	No No
5. Are	you taking any medicine -prescription medicine?	(s) including		Vac No		c. Sulfa drugs		Yes	No
				tes ino		d. Barbiturates, se	edatives, or sleepir	ng pillsYes	No
	/E YOU EVER HAD ANY			., .,				Yes	No
301	RGERY?			Yes No		f. logine	or paraetics	Yes	No No
a.	you or have you had any DAMAGED HEART VALVES	OR ARTIFICIAL HEART	VALVES,					Yes	No
	LUDING HEART MURMUR OF			.Yes No		I. Other			
	Cardiovascular disease gina, coronary insufficien				13.	Have you had any s	serious trouble ass	sociated with any	No
hio	h blood pressure, arterio	osclerosis, stroke)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Yes No				tes	INO
1.	Do you have chest pain	upon exertion?		.Yes No		11 30, explain			
2.	Are you ever short of br	eath after mild			14.	Do you have any di	sease, condition,	or problem not listed	
	exercise or when lying of	down?		.Yes No		above that you think	k I should know at	oout?Yes	No
3.	Do your ankles swell?.	ut defeate?		. Yes No		If so, explain			
4.	Do you have inborn hea Do you have a cardiac p	nacemaker?		. Yes No					
C.	Allergy, Sinus Trouble, F	Hav Fever		. Yes No	15.	Are you wearing co	ntact lenses?	Yes	No
d.	Fainting spells or seizur	es		. Yes No	16.	Are you wearing rei	movable dental ap	ppliances?Yes	No
e.	Persistent diarrhea or re	ecent weight loss		.Yes No	17.	Have you ever had	severe pains of th	e face and headYes	No
f.	Diabetes			.Yes No					
g.	HEPATITIS, jaundice or	liver disease		. Yes No			WOME	N	
	AIDS or HIV infection .				18.	Are you pregnant?			No
-	Thyroid problems Respiratory problems, en	nnhycoma acthma		. Yes No		Do you have any pr			
J.	Arthritis or painful swoll	en iointe		. Yes No		menstrual period?.		Yes	No
i.	Stomach ulcer or hyper	acidity		. Yes No				Yes	No
m.	Kidney trouble			.Yes No	21.	Are you taking birth	control pills?	Yes	No
n.	Tuberculosis			Yes No					
0.	Persistent cough or cou	gh that produces blo	ood	Yes No			DENTA	L	
p.	Persistent swollen gland MITRAL VALVE PROLA	ds in neck		. Yes No	1.	Do your gums bleed	d when you brush	your teeth?Yes	No
q.	MITRAL VALVE PROLA	PSE		. Yes No	2.	Have you ever had	excessive bleedin	g following	
	Sexually transmitted dis Epilepsy or other neuro							Yes	
	Problems with mental h							novocaine? Yes	
	Cancer							e on them? Yes	
	Problems of the immune							ou bite on them? Yes	No
W.	Frequent severe heada	ches		Yes No		Do you grind or cle			Nie
Χ.	Glaucoma			Yes No		nervous or while sie	eeping?	Yes	No
Chief D	ental Complaint								
Tillel D	ental Complaint								

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

AUTHORIZATION

I hereby authorize payment directly to the undersigned dentist of the surgical, dental, and/or Major Medical benefits, if any, otherwise payable and will pay any outstanding bill for services not covered by my insurance.

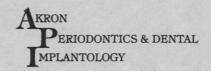
If I am turned over to a collection agency for non-payment of my bill, I agree to pay any and all fees incurred for this collection by the agency or attorney involved.

I, also, authorize the undersigned dentist to release any information and/or x-rays acquired in the course of my examination or treatment to my insurance company, and acknowledge that a photostatic copy of this authorization is as valid as the original.

Mark S	Ohernesser	DDS	MMSc	Inc

List Drugs Now Being Taken

Signature o	f Patient		
Date			



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

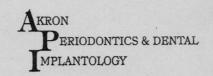
* You May Refuse to Sign This Acknowledgement*

l,	, have received a copy of this
office's	s Notice of Privacy Practices.
PI	ease Print Name
Si	gnature
Da	ate
	For Office Use Only
	empted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, buwledgement 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)
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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 April 14, 2003, 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 any time. For more information about out 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 reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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.

MARK S. OBERNESSER, D.D.S., M.M.Sc., INC

Akron Periodontics and Dental Implantology

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