NEW PATIENT REGISTRATION AND MEDICAL HISTORY

PATIENT INFORMATION

LAST NAME_____________________________

FIRST_________________________________

MIDDLE_______________________________

ADDRESS______________________________

CITY__________________________________

STATE______________ZIP______________

HOME PHONE (______)______-__________

EMPLOYER____________________________

WORK PHONE_________________________

OCCUPATION__________________________

CELL (_______) ________-____________

SOCIAL SECURITY_____________________

MARITAL STATUS______________________

BIRTHDATE _____/______/____________

RESPONSIBLE PARTY

NAME_________________________________

ADDRESS______________________________

CELL PHONE (______)________-__________

BIRTHDATE _______/_______/___________

SOCIAL SECURITY_____________________

RELATIONSHIP________________________

SPOUSE INFORMATION

LAST NAME____________________________

FIRST NAME___________________________

BIRTHDATE ______/_______/___________

SOCIAL SECURITY ____________________

EMPLOYER____________________________

CELL PHONE (______)________-_________

WHO MAY WE THANK FOR REFERRING YOU____

INSURANCE INFORMATION

INSURANCE NAME______________________

ID NUMBER____________________________

GROUP NUMBER_______________________

EMPLOYER____________________________

POLICY HOLDER INFORMATION

LAST NAME____________________________

FIRST NAME___________________________

BIRTHDATE _______/_______/_________

SECONDARY INSURANCE

INSURANCE NAME______________________

ID NUMBER____________________________

GROUP NUMBER_______________________

EMPLOYER____________________________

LAST NAME____________________________

FIRST NAME___________________________

BIRTHDATE _______/_______/_________

Patient Medical History

NAME OF PATIENT ______________________________

DOB ____________________

Question	Yes	No	
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 on special diet?	❍ Yes	❍ No	If yes, please explain: ____________
Have you had any metal rods, pins or implants placed?	❍ Yes	❍ No	If yes, please explain: ____________
Do you use tobacco?	❍ Yes	❍ No	If yes, how much? (pack/day) ____________
Do you use controlled substances?	❍ Yes	❍ No	____________

MEDICATIONS List any medications, pills or drugs you are currently taking:

____

____

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

ALLERGIES Are you allergic to any of the following?
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Local Anesthetics
- ☐ Latex
- ☐ Other

If yes, please explain:

____

____

HEALTH HISTORY Do you currently have, or have you ever had, any of the following conditions?

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

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: ______________________________

____

Comments: ______________________________

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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 ____________

Signature of Dentist ______________________ **DATE** ____________

DENTAL HISTORY

Purpose of initial visit____________________

____

Are you aware of a problem?_______________

____

How long since your last dental visit?_________

____

What was done at your last visit?____________

____

Previous dentist___________________________

Were dental x-rays taken?__________________

Have you had any teeth extracted?__________

If so, why?______________________________

Any complications after removal?____________

Have the teeth been replaced? When and How?

____

____

Do you clench or grind your teeth?__________

Does your jaw click or pop?________________

Have you experienced any pain or soreness in the muscles of your jaw or ear? _____________

Does food get caught between your teeth?

____

Are your teeth sensitive? If so, to what?______

____

How often do you brush your teeth?_________

____

Do you floss your teeth? How often?_________

____

Do your gums bleed or hurt when brushing?___

____

Has anybody told you your breath is offensive?

____

How do you feel about your teeth in general?

____

Any unpleasant dental experiences?_________

If you could change anything about your smile, what would it be?______________________

____

I certify that the above information is complete and accurate.

Signature of Patient/Guardian____Date__________________

David S. Muir, D.D.S., P.L.L.C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DSICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOU HEALTH INFORMTION 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 following your initial patient appointment 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 or 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 you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operation include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluation 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 for those described in this notice.

To Your Family and Friends: We muse disclose your health information to you, as described n 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use or 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 official's 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 copies, we will charge you $0.15 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 purpose, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2014. 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 the 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.
Contact Officer: ______________________________
Telephone: ______________________ Fax: ______________________
Email: ______________________________
Address: ______________________________

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This form is educational only, does not constitute legal advice and covers only federal not state Law.

David S. Muir, D.D.S, P.L.L.C

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ____________________________, have received a copy of the office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

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

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o Emergency situation prevented obtaining acknowledgement
- o Other (Please Specify)

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