PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ ZIP _____ PHONE _____ CELL _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ EMAIL _____

RESIDENCE ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____

PATIENT'S SSN _____ INSURED'S SSN _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT? ☐ YES ☐ NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? INDICATE WITH A ✔

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long? _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad Breath
- ☐ Unpleasant Taste
- ☐ Unfavorable dental appearance
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Mouth breathing
- ☐ Oral habits, ie. fingernail biting cheek biting, etc.
- ☐ Do you use tobacco?
- ☐ Texture or Toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Fluoride supplements

Office Use Only

BP_____/_____ Heart Rate _____

MEDICAL HISTORY

Y N
- ☐ ☐ Are you taking birth control?
- ☐ ☐ Are you pregnant? If yes, # of weeks _____
- ☐ ☐ Are you nursing?

Y N
- ☐ ☐ Do you smoke or use tobacco?I

Height _____ Weight _____
- ☐ ☐ Is your blood pressure high?

Y N
- ☐ ☐ Do you snore?
- ☐ ☐ Are you frequently tired?
- ☐ ☐ Has anyone ever observed your breathing stop while sleeping?

Y N Conditions
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Allergies
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Are you allergic to SULFA drugs?
- ☐ ☐ Arthritis
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Asthma
- ☐ ☐ Blood Transfusion
- ☐ ☐ Cancer - Chemotherapy
- ☐ ☐ Colitis
- ☐ ☐ Cosmetic Surgery
- ☐ ☐ Diabetes
- ☐ ☐ Drug Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Fever Blisters
- ☐ ☐ Frequent Headaches
- ☐ ☐ Glaucoma
- ☐ ☐ HIV+ Aids

Y N Conditions
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur/ Mitral Valve Prolapse
- ☐ ☐ Heart Surgery
- ☐ ☐ Hemophilia
- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ Hepatitis C
- ☐ ☐ High Blood Pressure
- ☐ ☐ Joint Replacement
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Osteoporosis/Osteoperia
- ☐ ☐ Pace Maker
- ☐ ☐ Pneumocystitis
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Seizures
- ☐ ☐ Shingles
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Sinus Problems

Y N Conditions
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐ Yellow Jaundice

Y N Allergies
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Jewelry
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Penicillin
- ☐ ☐ Tetracycline

Other

Medications

_____

_____

Y N
- ☐ ☐ Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes, please describe below...

_____

_____

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bills. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

** You may refuse to sign this acknowledgement **

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

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 obtain because:

____ Individual refused to sign
____ Communication barrier prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (please specify):
_____
_____
_____

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 to appropriate authorities 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 serious threat to your 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 institutions or law enforcement official having lawful custody of protected health information of an 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, we will charge you $0.10 for each page and $1.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you chose 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 Amount: 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 14th, 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 request.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your healthcare information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in 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 website or by electronic mail (email), you are entitled to receive this notice in written form.

Questions or Complaints

If you want more information about our privacy policies 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 may also 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 the U.S. Department of Health and Human Services.

Contact Officer: Front Desk Staff
Telephone: (702) 896-8933
Email: gvdental@embarqmail.com
Address: 275 N. Pecos Rd.
Henderson, NV 89074

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 law and state law to maintain the privacy of your health information. We are also required to give you 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 March 28th, 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 or our notice effective for health change in our privacy practice; 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 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 or disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use or 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 healthcare information for treatment, payment, or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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.
Person 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, your care your location, your general condition or death. If you are present, then prior to you use or disclosure to 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 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 practices 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.