Advanced Dental Implant Solutions

Name ____ Soc. Sec. # ______________
Last Name First Name Middle Initial
Address ____ How long at this address?________
City _____________________ State _____ ZIP _______ Home Phone __________________
Cell Phone __________________ Email ____
Sex □ M □ F Age____ Birth date _______ □ Single □ Married □ Widowed □ Separated □ Divorced
Employer _____________________ Number of Years _____ Occupation __________________
Business Phone ____
Whom may we thank for referring you? ____
Notify in case of Emergency __________________________ Phone ______________________

Primary Insurance

Person Responsible for Account ____
Last Name First Name Middle Initial
Relationship to Patient ____________ Birthdate __________ Social Security # ______________
Address (if different from patient) ____
City _____________________ State _____ ZIP _______ Phone Number _________________
Cell Phone __________________ Email ____
Employer _______________________________________ Occupation __________________
Business Phone____
Insurance Company ________________________________ Phone ______________________
Group #__________________________ ID # ______________________________________

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No
Subscriber Name __________________ Relationship to Patient __________ Birthdate _________
Address (if different from patient) _________________________ Social Security # ______________
City _____________________ State _____ ZIP _______ Home Phone __________________
Cell Phone __________________ Email ____
Subscriber's Employer ______________________________ Business Phone _______________
Insurance Company ________________________________ Phone ______________________
Insurance Email ____
Group #__________________________ ID # ______________________________________

I understand that it is my responsibility to contact my dental insurance company to determine what dental insurance benefits I have available. I understand that as a courtesy West7th Smiles will help me obtain this information and file my claims for dental work performed at their office. I also understand that I am responsible for all expenses not covered by my insurance due at the time of service.

Signature (Parent/Guardian Signature, if minor) ____

Advanced Dental Implant Solutions

Dental History

Patient Name: ________________________________ Medical Alert: ____________________________

We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

What is the reason for your visit today?____

____

Date of Last Dental Visit_________________ **Last Dental Cleaning**_________________ **Last Full Mouth X-rays**__________________

What was done at your last dental visit?____

____

Previous Dentist's Name____ Telephone_____________________

Address____ City ______________________State________ ZIP _________

How often do you have dental examinations? ____

How often do you brush your teeth? _____________________________ How often do you floss? ________________________________

What other dental aids do you use? (Interplak, toothpick, etc.)____

Do you have any dental problems now? Yes No

If yes, please describe: ____

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes, where? ____________________

Do you:
Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails, etc.) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleep disorders? Yes No
Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:
Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or your bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause___________
____

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of the face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? _____________
____
Have you ever had an upsetting dental experience? Yes No
If yes, please describe________________________
____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe ____
____
____
____

Advanced Dental Implant Solutions

Medical History

Patient Name: ____ Birth Date ___________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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 taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	________________
Are you on a special diet?	Yes	No	________________
Do you use tobacco?	Yes	No	________________
Do you use controlled substances?	Yes	No	________________

Women: Are you… Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medication	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors/Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

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

Comments: ____

____

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 ____________________

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected information (PHI) to carry out treatment, payment or health care operations (TPO) 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 or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your Dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice and any other use require by law.

Treatment: we will use and disclose your protect health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information to be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate
your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information as necessary to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You might revoke this authorization at any time, in writing except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following record, 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 have the right to request a restriction of your protected health information. This means you may ask is not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friend who may be involved on your care or for notification purpose as describes in this Noticed of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you nay request. If dentist believes it is in best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/ or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number

Signature below in only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name ___________________________________

Signature ____________________________________

Date: _____________________

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: ____
First Name Middle Name Last Name

2. **Date of Birth**: ___/___/___ 3. **SSN**: ____-____-_____ 4. **Date authorization initiated**: ___/___/___

5. **Authorization initiated by**: ____
Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed**:
- ☐ My dental information relating to the following treatment or condition: ____________________
- ☐ Most recent ___ years of record
- ☐ My dental records for the following date(s): ____________________
- ☐ Entire dental record
  - ☐ Include ☒ Exclude: My health information related to drug and/or alcohol abuse
  - ☐ Include ☒ Exclude: My health information related to HIV/AIDS
- ☐ Other information to be used or disclose (describe information in detail): ____________________

7. **Purpose of Use or Disclosure**:
- ☐ Treatment, Payment or Health Care Operations
- ☐ Disclosure to Life Insurer for Coverage Purposes
- ☐ Disclosure to Employer of results of pre-employment physical or lab tests
- ☐ Marketing Purposes
- ☐ To the Following Family Members: ____________________
- ☐ Other (describe each purpose of the requested use and disclosure in detail): ____________________

8. **Person(s) Authorized to Make the Disclosure**: ____________________

9. **Person(s) Authorized to Receive the Disclosure**: ____________________

10. **This Authorization will: ☐ not expire, ☐ expire on ___/___/___ or ☐ upon the happening of the following event**: ____________________

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: ____________________

Signature of Personal Representative: ____________________

Relationship to Client if Personal Representative: ____________________

Date of signature: ___/___/___

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   ____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.