Patient Information and Health History

In order to help us render the proper dental services to you, would you please answer the following questions? The information you give us is held strictly confidential and will not be released to anyone without your permission. Thank you for your cooperation.

Personal Information *(Please Print)*

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth ___/___/___ Social Security Number _____ E-mail Address _____

Employed by _____ Position _____

Spouse's Name _____

Spouse Employer _____ Business Phone _____

Who may we thank for referring you? _____

Person or Relative not living with you we can notify in case of an emergency _____

Phone Number _____

Party responsible for payment (if other than youself):

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Insurance Information

Name of person carrying the insurance _____

Social Security Number of Insured _____ Date of Birth ____ / ____ / ____

Relationship to Insured Self _____ Spouse _____ Child _____ Other _____

Employer _____

Insurance Company _____ Group / Policy Number _____

Name of person carrying second insurance _____

Relationship to Insured Self _____ Spouse _____ Child _____ Other _____

Social Security Number of Insured _____ Date of Birth ____ / ____ / ____

Employer _____

Insurance Company _____ Group / Policy Number _____

Release and Authorization

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that my dental insurance carrier may pay less than my actual bill for services. I authorize payment of the dental benefits to be paid directly to the provider of services, and to the extent permitted by law, authorize release of any information related to submitted dental claims.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)

Medical History

Physician's Name _____

Address _____ Phone _____

Last Complete Physical? _____ Do you have any current medical problems? _____

_____

_____

Yes ❒ No ❒ Have you had any serious illness or condition requiring hospitalization or surgery?

When? _____

What for? _____

Yes ❒ No ❒ Have you ever had abnormal bleeding associated with extractions or surgery?

_____

_____

Please list any prescription medications you are now taking:

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Please list any nonprescription medications you take on a regular basis (i.e., herbal or vitamin supplements, breath mints, cough drops, antacids, etc.)

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Are you allergic or have you reacted adversely to any of the following?

Please circle:	Penicillin	Yes ❒ No ❒	Local Anesthetics	Yes ❒ No ❒	
	Cephalexin	Yes ❒ No ❒	Latex	Yes ❒ No ❒	
	Antibiotics	Yes ❒ No ❒	Acrylic	Yes ❒ No ❒	
	Pain pills	Yes ❒ No ❒	Other		

Please describe the reaction _____

Please Note: *The use of local anesthetics and some prescription medications on an individual using undisclosed substances such as cocaine, amphetamines, diet pills or anabolic steroids could trigger severe and even fatal reactions. Any substance disclosure is held in strict confidence.*

Indicate which of the following you have had, or have at present. *(Circle "Yes" or "No" to each item.)*

Heart (Surgery, Disease, Attack)	Yes	No	Allergies or Hives	Yes	No
Chest Pain	Yes	No	Sinus Trouble	Yes	No
Congenital Heart Disease	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Chemotherapy	Yes	No
High Blood Pressure	Yes	No	Tumors	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatits A (infectious) B (serum) C	Yes	No
Artificial Heart Valve	Yes	No	A.I.D.S.	Yes	No
Heart Pacemaker	Yes	No	Cold Sores / Fever Blisters	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No
Arthritis/Rheumatism	Yes	No	Hemophilia	Yes	No
Swollen Ankles	Yes	No	Sickle Cell Disease	Yes	No
Stroke	Yes	No	Bruise Easily	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Liver Disease	Yes	No
Kidney Trouble	Yes	No	Neurological Disorders	Yes	No
Ulcers	Yes	No	Epilepsy or Seizures	Yes	No
Diabetes	Yes	No	Fainting or Dizzy Spells	Yes	No
Thyroid Problems	Yes	No	Nervous / Anxious	Yes	No
Glaucoma	Yes	No	Psychiatric / Psychological Care	Yes	No
Contact Lenses	Yes	No	Bulimia	Yes	No
Emphysema	Yes	No	Anorexia	Yes	No
Chronic Cough	Yes	No	Osteoporosis	Yes	No
Tuberculosis	Yes	No	Fibromyalgia	Yes	No
Asthma	Yes	No	Lupus	Yes	No
Hay Fever	Yes	No			

WOMEN

Are you pregnant? Yes ❒ No ❒ If yes, how many months? _____

Are you taking birth control medication? Yes ❒ No ❒

Do you anticipate becoming pregnant? Yes ❒ No ❒

Are you breast feeding? Yes ❒ No ❒

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or the medications I take, I will inform the doctor or a staff member at my next visit.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)

Dental History

When were you last seen by a dentist? _____ Name of Dentist _____

Was that visit for routine care or emergency treatment? _____

Were you satisfied with the treatment you received there? _____

What is your chief reason for making this appointment? _____

_____

Please circle "Yes" or "No". If Yes, please give details.

Yes No Are you currently experiencing any pain or discomfort? _____

Yes No Are your teeth sensitive to ❒ Hot ❒ Cold ❒ Sweets ❒ Pressure?

Yes No Do you experience discomfort while chewing? _____

Yes No Are you bothered by bad breath or a persistent bad taste in your mouth? _____

Yes No Do your gums bleed while brushing? _____

Yes No Have you ever been told you have gum disease? _____

Yes No Does food catch between your teeth? _____

Yes No Have you ever had periodontal treatment (gum surgery)? _____

Yes No Do you experience any popping or clicking in your jaw while chewing? _____

Yes No Are you aware of grinding or clenching your teeth? ❒ Occasionally ❒ Quite often ❒ Never

Yes No Are you unhappy with the appearance of your smile? _____

Yes No Do you feel you will eventually wear full dentures? _____

Yes No Do any members of your family including your parents wear full dentures? _____

Yes No Do you think your dental disease is active? _____

Yes No Do you have a fear of dental treatment? ❒ Mild ❒ Moderate ❒ Severe

Yes No Have you ever had orthodontic treatment (braces)? _____

Yes No Have you ever had a traumatic dental experience? Please describe _____

_____

_____

Yes No Is there anything else about your dental history you feel I should know? _____

_____

_____

I authorize dental treatment to be performed by the dentist and his delegated staff.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)

Prairie Dental Care L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

_____

_____

_____

Prairie Dental Care L.C.

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 4/14/03, 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 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 copies, we will charge you $0._____ for each page, $_____ 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 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.

Contact Officer: Veronica Bergonzoni

Telephone: 913/649-7272 Fax: 913/649-8275

E-mail: NEWSMILE@PRAIRIEDENTALCARE.COM

Address: 7515 NALL PRAIRIE VILLAGE, KS 66208