

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? <input type="checkbox"/> Does it hurt to chew, bite or swallow? <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/> Do you clench or grind your teeth? <input type="checkbox"/> Does your jaw click, pop or hurt? <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?			Yes No ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use vaping products ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnant ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?	Yes	No	?
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)

Other

Please describe any "Yes" answers and include information about your experience. _____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)? _____

Doctor's Name: _____ Phone: _____

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes to any of the above, please explain: _____			

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?			Yes	No	?				Yes	No	?	
Heart (Cardiac) Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____		Digestive Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of diagnosis: _____		Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy: _____		G.E. reflux/persistent heartburn (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment: _____		Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (Circulatory) Health			Eye (Vision) Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____		Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain (Neurological)/Mental Health			Arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Breathing (Respiratory) Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____			Sexually transmitted infection (STI)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?	Yes	No	?	Yes	No	?	
had pain or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
had a rapid or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							experienced vomiting, diarrhea, chills, night sweats or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							had migraines or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____

GENERAL DENTISTRY INFORMED CONSENT FORM

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. REMOVAL OF TEETH (EXTRACTION)

Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the tooth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Patient signature: _____ Date: _____

Patient Name (Print): _____



OFFICE POLICIES

Dental Insurance: Submission of insurance claims is a COURTESY that our office provides but not an obligation. We can only ESTIMATE what the insurance will cover based on what they tell us. Each insurance company has their policies for benefits and exclusions. It is the patient's responsibility to familiarize themselves with the type of coverage and limitations of their insurance policy. Co-payments are due at the time that services are rendered unless other financial arrangements have been made. Therefore, it is the patient's responsibility for the difference in payments. We will not be held responsible for charges incurred after the maximum has been exceeded, waiting periods, clauses and/or benefit termination.

Recall/Hygiene Appointments: Our office adheres to ADA recommendations in regards to x-rays and dental cleanings which are: full mouth x-rays or panoramic once every 3 to 5 years; bitewing x-rays every 6 to 12 months and dental cleanings twice per year (every 6 months) MINIMUM. Please keep in mind that two cleanings per year is the minimum. Each individual has different needs based on the health of their mouth.

Refusal of Treatment, Exams and X-rays: There is a standard of care that our office must adhere to. It is impossible for us to make a proper diagnosis and treatment plan without current x-rays and a dental examination. It is our OBLIGATION to inform you of existing problems in your mouth, therefore, all patients who refuse exams and appropriate x-rays should seek help elsewhere as our office would not be able to provide you with the quality of care that we believe in. All patients are welcome to seek a second opinion elsewhere. For those who refuse treatment, it is certainly your right, and therefore we would kindly ask you to sign a LETTER of REFUSAL for treatment which states that our office has informed you of the need of treatment and the possible consequence if left untreated and that you are fully aware of the consequence and would take full responsibility of it.

Broken Appointment: We have a STRICT cancellation policy. We do not overbook patients in anticipation of no-shows or last minute cancellations therefore it is important that you keep scheduled appointment. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes if possible. However, when appointments are scheduled our dentist's and/or hygienist's time is reserved for you and it is unavailable to other patients who need to schedule an appointment.

We strive to see patients on time for scheduled appointments; however there are times when our schedule is delayed in order to accommodate an emergency or complication in a scheduled procedure. Please accept our apology should this occur during your appointment.

Follow our standard policy for broken appointments:

Broken/Missed Appointments: There is a \$50 broken appointment fee for missed appointments or cancelled with less than 48 hours notice. Please note that if you need to cancel appointments that are scheduled on a Monday, our office needs to be notified by Thursday at noon time as our office is closed on the weekends. If 2 broken appointments occur, our office reserves the right to not schedule any subsequent appointments for you.

Reminder of Appointments: Reminder of appointments is a COURTESY that our office provides not an OBLIGATION. We suggest that you call our office if you are unsure of the time and/or date of your appointment because there WIL BE a broken appointment charge if you do not show up.

I have read and fully understand and agree with the broken appointment policy of Vibhi Vellanki ,Inc.

Privacy Practices Acknowledgement (HIPPA): I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient, Parent, Guardian

Name of Patient, Parent, Guardian

DATE



Financial Responsibility for account:

Who is responsible for this account: _____

Relationship to patient: _____

Dental Insurance Assignment & Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to the dentists at New Horizons Family Dental and/or Vibhi Vellanki Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Name of Patient, Parent, Guardian or Personal Representative

Signature of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Date

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose medical 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 share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law

enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You 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. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.