Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

## PATIENT REGISTRATION

Patient's Name: _____ Preferred Name:_____
First Middle Initial Last
Date of Birth: _____-_____-_____ Sex: M F
Address: _____ Apt # :_____City: _____
State: _____ Zip: _____ Home Ph#: ( ) _____- _____ Work Ph#: ( ) _____- _____
Cell #: ( ) _____- _____ Pager#: ( ) _____- _____

Emergency Contact Name: _____ Emergency Contact Ph#( ) _____- _____

Who can we thank for referring you? _____

## ACCOUNT INFORMATION

Who is financially responsible for this account? _____
Date of Birth: _____-_____-_____ DL#/State: _____

Address: _____ Apt # :_____City: _____
State: _____ Zip: _____ Home Ph#: ( ) _____- _____ Work Ph#: ( ) _____- _____
Cell #: ( ) _____- _____ Pager#: ( ) _____- _____ Relationship to Patient: _____
Employed By: _____ Occupation: _____
Employer's Address: _____ Suite#: _____ City: _____
State: _____ Zip: _____

## DENTAL HISTORY

| | | | |
|---|---|---|---|
| 1. | Are you having any immediate dental problems? ____ If so, please explain: _____ | | |
| 2. | When was your last visit to the Dentist? _____ | | |
| 3. | When was your last dental cleaning? _____ | | |
| 4. | Who was your last Dentist? _____City: _____State: _____ | | |
| 5. | Are you satisfied with your past dental experience? | Yes | No |
| 6. | How often do you brush your teeth? _____ Floss? _____ | | |
| 7. | Has fear or discomfort kept you from seeing a dentist on a regular basis? | Yes | No |
| 8. | Do your gums bleed easily, feel tender or irritated? | Yes | No |
| 9. | Are your teeth sensitive to hot, cold or sweets? | Yes | No |
| 10. | Does your jaw feel tired? | Yes | No |
| 11. | Do you have pain in the head, neck, shoulders or back? | Yes | No |
| 12. | Do you have clicking or hear popping noises when opening or closing your mouth? | Yes | No |
| 13. | Are you aware of grinding or clenching your teeth? | Yes | No |
| 14. | If so, do you wear a night guard? | Yes | No |
| 15. | Would you like to retain healthy natural teeth as long as possible? | Yes | No |
| 16. | Do you have any problems using Nitrous Oxide or Local Anesthetic? | Yes | N |

## MEDICAL HISTORY

Physician's Name: _____ Office Ph#: _____
Address: _____ City: _____ State: _____Zip: _____

| | | | |
|---|---|---|---|
| Are you being treated by a physician now? | Yes | No | Identify: _____ |
| Are you taking any medication? | Yes | No | Identify: _____ |
| Are you allergic to any medication? | Yes | No | Identify: _____ |
| Are you allergic to metals? | Yes | No | Identify: _____ |
| Have you had any recent serious illnesses | Yes | No | Identify: _____ |
| Have you ever had any major surgeries? | Yes | No | Identify: _____ |

Please CIRCLE any of the following which you have had or have at present:

**Heart Trouble** **Stroke** **High Blood Pressure**
**Diabetes** **Rheumatic Fever** **Kidney/Liver Disorder** **Eye Disorders** **Tumors/Growths** **Prolonged Bleeding**
**Tuberculosis** **Asthma** **Epilepsy**
**Hepatitis** **AIDS (HIV +)** **Radiation Treatment**
**Venereal Disease** **Arthritis** **Currently Pregnant**
**Smoking/Smokeless Tobacco** **Thyroid Condition** **Stomach/Intestinal Problems**
**Birth Control Pills** **Heart Murmur** **Artificial Heart Valve**
**Heart Pacemaker** **Artificial Joints** **Latex Sensitivity**
**Cold Sores/Fever Blisters** **Fainting or Dizzy Spells** **Glaucoma**
**Psychiatric/Psychological Care** **Allergic to Anesthetic** **Bruise Easily**
**Ulcers**

Are there any other medical problems that we should be aware of? Yes No If yes, please explain:

_____

_____

_____

## CONSENT FOR TREATMENT

1. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication.
2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made prior to the services being rendered.

Patient Signature: _____Date: _____

Parent/Responsible Party Signature: _____ Date: _____

# *Notice of Privacy Practices*

*Effective January 1, 2014*

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information ("IIHI") used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. HIPAA gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your IIHI information and how we may disclose your IIHI information. The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. We may use and disclose your medical records only for each of the following purposes:

1. Treatment, Payment, and Healthcare Operations

    - Treatment means providing, coordinating or managing healthcare related services by one or more healthcare providers. An example of this would include teeth cleaning services.
    - Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
    - Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, and cost management analysis and customer service. An example would be an internal quality assessment review.

2. Pursuant to an individual's written authorization that meets HIPAA's criteria (i.e. specifying who is to receive the IIHI).

3. As required for compliance with the HIPAA Administrative Simplification Rules.

We also may create and distribute re-identified health information by removing all references to individually identifiable information. Further, we may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. The following categories describe the unique scenarios under which we may use or disclose your IIHI:

**Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purposes of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our office
- To identify/locate a suspect, material witness, fugitive, or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator.)

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**ndividual Rights.** You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer. **[The privacy officer is Sharalyn Fichtl and she may be reached at 469-343-7888]**

1. The right to request restrictions on certain uses and disclosures of health information. Please note we are not required to agree with your request. For example, you may designate family members, relatives, close personal friends or any other person identified by you to receive disclosures and/or specify persons who will not receive any health information.
2. The right to reasonably request to receive confidential communications of protected health information from us in a particular manner or at a specified location. For example, you may request that we contact you only at home and not work, for appointment reminders or any other communication.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information that you believe is incorrect or incomplete, by following specific procedures set forth in HIPAA. We may deny your request in certain situations, e.g., the information is accurate or was provided by a third party, such as a laboratory.
5. The right to receive an accounting of certain disclosures of protected health information upon written request and by meeting the conditions set forth in HIPAA.
6. The right to obtain a paper copy of this Notice.

**Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Sharalyn Fichtl at 469-343-7888.** All complaints must be submitted in writing. You will not be penalized for filing a complaint. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Your private health information cannot be sold. You have the right to opt out of being contacted about fundraising. You have the right to restrict our practice from disclosing your out of pocket expenses. You have the right to limit our practice from disclosing genetic information. We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

**For more info about HIPAA:**
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201

**Imagine Dental**
3507 Jaime Zapata Memorial Hwy #3
Laredo, TX 78043

**Privacy Officer**
Sharalyn Fichtl
469-343-7888
202-619-0257

## AKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

***(You may refuse to sign)***

I, (print name)_____, have received a copy of this offices Notice of Privacy Practices.

_____

{Please Print Name}

_____

{Signature Patient or guardian if under 18)

## Office use only

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited patient from signing acknowledgment
- ☐ Emergency situation prohibited patient from signing acknowledgment
- ☐ Other(please specify below)

_____

_____

_____

_____

# Confidential Communication Agreement

Signature:_____ Date:_____

Name:_____ Tel: _____

If not signed by patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of incompetent patient

Beneficiary or personal representative of deceased patient

Name of Patient(s):_____

Please list family members or other persons, if any, of whom we may discuss your dental treatment and/or diagnosis:

Name:_____ Tel:_____ Relation:_____

Name:_____ Tel:_____ Relation:_____

Name:_____ Tel: _____ Relation:_____

Please list the family memners or other persons, if any, with whom we may discuss your dental treatment ONLY IN EMERGENCY:

_____ Same as above

_____ None

Name:_____ Tel: _____ Relation:_____

Name:_____ Tel: _____ Relation:_____

Name:_____ Tel:_____ Relation:_____

Please print the Telephone number, if any, where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions. Tel: _____

May confidential messages be left on the answering machine or voice-mail to the number given above? ___ Y ___N

If you do not have an answering machine or voice-mail, may a confidential message be left with a secretary or personal assistant? _____Y _____N

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions Dr.s Salinas, Sparacino or any Imagine Dental dentists and employees took before receiving my revocation. I also understand and consent that the Imagine Dental group of dentists share proceeds as part of their arrangement in bringing me excellent dental care.

Print name_____Signature_____Date_____