QUIVIRA PARK
FAMILY DENTISTRY

Date _____

Patient's Name_____ **Date of Birth** _____

First MI Last Nickname

Social Security Number:_____**Sex:** M or F **Marital Status:** Single/Married/Divorced/Widowed/Child

Address: Street _____

City _____**State**_____ **Zip code**_____

Home Phone (___)_____**Cell Phone (___)**_____ **Work Phone(____)**_____

EMAIL ADDRESS _____

Driver's License Number _____State:_____

Employer_____Position:_____

Employer Address _____ City _____ State ____ Zip Code_____

Spouse or Parent's Name:_____Phone: (_____)_____

Address (if different than above):_____

INSURANCE (Please present your Insurance cards for us to copy)

Primary Dental Ins. Co:_____ Secondary Dental Ins. Co:_____

Policy Holder_____ DOB:_____ Policy Holder :_____DOB:_____

Relationship to patient: _____ Relationship to patient: _____

Employer: _____ Employer: _____

ID#_____ Group #:_____ ID#_____ Group #:_____

NOTE: We will gladly bill your insurance for you; however you are still responsible for deductible, patient portion and any other balances at the time of service. If you have any other insurance please notify front desk.

RESPONSIBLE PARTY:

Name: _____ Relationship to patient _____

Address: _____ City _____ State _____ Zip code_____

Employer_____ Date of Birth _____

Home Phone: (___)_____Cell Phone:(___)_____ Work Phone:(_____)_____

How did you hear about our office? _____

Emergency contact information _____

Name Address Phone

Authorization and Release: I certify that the above information is accurate to the best of my knowledge. I hereby authorized Quivira Park Family Dentistry to administer treatment, x-rays, anesthetics, to perform dental procedures as deemed necessary or advisable in the diagnosis and treatment of my dental condition. I realize that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to this practice. I understand that it is my responsibility to notify Quivira Park Family Dentistry if any of the above information changes.

If unable to keep an appointment, kindly give 48 hours notice. Otherwise a charge may be made for the time that was reserved for you.

Signature of Patient (Parent/Guardian if minor)_____Date:_____

QUIVIRA PARK FAMILY DENTISTRY

MEDICAL HISTORY FORM

Patient's Name_____

Physician's Name:_____Phone No:._____Date of last Physical:_____

Have you been hospitalized or under a Dr's care in the last 2 yrs?_____Reason:_____

How would you describe your health?_____Do you have any other health care providers?_____

Do you use tobacco?_____

Type Amount Frequency

Please list all prescription, non-prescription medications, and herbal products that you are presently taking:

Medication Condition Dosage Frequency

_____

_____

_____

_____ (Use back of form for additional medications.)

Do you routinely take: Aspirin?_____Blood Thinners?_____Biophosphonates?_____

Do you need to take an ANTIBIOTIC PRIOR TO DENTAL TREATMENT?_____For:_____(ex. Joints replacements)

Are you on a special diet?_____

Do you use any controlled substances?_____Do you use alcohol?_____Frequency_____

WOMEN: Are you pregnant?_____Nursing?_____Taking birth control pills?_____

Are you ALLERGIC to any medications/ substances? (Penicillin, latex, sulfa, codeine, etc)

Medication/Substance Reaction

_____

_____

Do you have, or have you had, any of the following? Please circle.

AIDS/HIV Positive	Chemotherapy	Frequent Headaches	Leukemia	Sickle Cell Disease
Alzheimer's Disease	Chest Pains	Glaucoma	Liver Disease	Sinus Trouble
Anaphylaxis	Cold Sores/Fever blisters	Hay Fever	Low Blood Pressure	Sleep Apnea or snoring
Anemia	Congenital Heart Disorder	Heart Attack/Failure	Lung Disease	Spina Bifida
Angina	Convulsions	Heart Murmur	Mitral Valve Prolapse	Stomach/Intestinal Disease
Arthritis/Gout	Cortisone treatments	Heart Trouble/Disease	Osteoporosis	Stroke
Artificial Heart Valve	Diabetes	Hemophilia	Pace Maker	Swelling of Limbs
Artificial Joint	Easily Winded	Hepatitis A, B or C	Parathyroid Disease	Thyroid Disease
Asthma	Emphysema	Herpes Simplex	Psychiatric Care	Tonsillitis
Blood Disease	Epilepsy or Seizures	High Blood Pressure	Radiation treatments	Tuberculosis
Blood Transfusion	Excessive bleeding	High Cholesterol	Rapid Weight Loss	Ulcers
Breathing Problem	Excessive thirst	Hives or Rash	Renal Dialysis	Veneral Disease
Bruise Easily	Fainting spells/dizziness	Hypoglycemia	Rheumatic Fever	Yellow Jaundice
Cancer	Frequent Cough	Irregular Heartbeat	Scarlet Fever	
Chemical Dependency	Frequent Diarrhea	Kidney Problems	Shingles	

Have you ever had any serious illness not listed above?_____Please explain: _____

_____

DENTAL HISTORY

What are your present dental concerns?_____When was your last dental visit?_____

Who was your last dentist? _____May we contact the office?_____

Do you feel you have cavities? _____ Have you avoided regular dental care? _____

Do you feel you have gum disease? _____ Have you ever had periodontal (gum) treatments? _____

Do you have problems getting numb? _____Are you interested in whitening your teeth? _____

Are you happy with the appearance of your teeth?_____If not, what would you like to change?_____

How often do you brush?_____Floss?_____Use other cleaning aids?_____

If you have a denture or partial, are you happy with it?_____How long have you had the current denture/partial?_____

Do you currently have problems with any of the following? (Please circle those that apply)

Bleeding gums	Pain when chewing	Missing teeth	Frequent tooth or fillings breaking
Bad Breath	Jaws clicking or popping	Sore areas in the mouth	Loose or chipped teeth
Unpleasant taste	Clenching or grinding teeth	Headaches or neck pain	Teeth sensitive to pressure, sweet, hot or cold
Food getting caught between teeth			

Additional Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing 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:_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Patient Name: _____

Relationship to Patient: _____

Date: _____

Office Use

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices
Acknowledgement, but was unable to do so as documented below:
Date: _____ Initials: _____ Reason: _____

_____

QUIVIRA PARK
FAMILY DENTISTRY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care 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.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost -management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We many 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.

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.

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 right to request restrictions on certain uses an d disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. WE are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request