WELCOME

Patient Information

Name_____SS #_____Date _____
First MI Last

Address_____City_____State_____ Zip_____

Birthdate_____ Home Ph._____Work Ph._____ Cell Ph. _____

Email Address_____

Are you: ☐Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Employer_____Occupation_____

Spouse or Parent's Name_____ Employer_____ Phone_____

How did you hear about us? (Referral, newspaper, yellow pages, etc.) _____
If referral, whom may we thank?_____

Responsible Party *(Please present insurance card to receptionist)*

Person responsible for account_____ SS #_____ Birthdate_____

Relationship to patient_____ Home Phone_____ Work Phone_____

Address_____ City_____ State_____ Zip_____

Dental History

Former Dentist_____ Date of last exam_____ Date of last xrays_____

Reason for today's visit_____

How often do you brush?_____ How often do you floss?_____

Please check any of the following conditions that apply to you:

☐Bad Breath	☐Grinding Teeth	☐Sensitivity to hot
☐Bleeding Gums	☐Loose teeth or broken fillings	☐Sensitivity to sweets
☐Clicking or popping jaws	☐Periodontal Treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Sores or growths in mouth	☐Sensitivity to cold

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HEALTH HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

For the following questions, please circle whichever applies. Your answers are for our records only and will be considered confidential.

Date of last physical exam: _____ Physician name: _____ Phone: _____

Have you had an artificial joint replacement (hip, knee, etc)? Yes / No
If so, when? _____ Name of physician: _____

PLEASE CIRCLE to indicate your response if you have had any of the following diseases or problems:

Damaged heart valves__ artificial valves__ Rheumatic fever__ or heart murmur__? Yes / No

Has any doctor told you to take antibiotics before your dental appointment? Yes / No
When? _____ Who? _____

Heart disease__ heart attack__ angina__ or any other heart condition__? Yes / No

Do you have a Pacemaker? Yes / No

High blood pressure __ Low blood pressure__ Stroke__ Arteriosclerosis__? Yes / No

Asthma__ sinus trouble__ hay fever/seasonal allergies__ Food__ Animals__? Yes / No

Fainting spells, seizures or epilepsy? Yes / No

Diabetes Type I or II ? Insulin dependent? Yes / No

Hepatitis, jaundice or liver disease? __ Thyroid problems? __ Kidney trouble?__ Yes / No

Tuberculosis__ respiratory problems__ emphysema__ bronchitis__ etc? Yes / No

Stomach ulcer or hyperacidity? Yes / No

Cancer? Type: _____ Chemo ___ Radiation ___ Yes / No

Received or waiting for a transplant? _____ Yes / No

Any drug or disease that has suppressed your immune system? Lupus__ MS ___ HIV__ Yes / No

Have you ever taken medication for osteoporosis? Pill___ IV___ Injection___ Yes / No

Do you use tobacco (smoking, snuff, chew,)? Yes / No

Are you allergic to or have you had a reaction to:

Local anesthesia "Novacaine"	Yes / No	Aspirin	Yes / No
Penicillin	Yes / No	Codeine or other narcotic	Yes / No
Sulfa Drugs	Yes / No	Latex	Yes / No
Barbiturates, sedatives,sleeping pills	Yes / No	Iodine	Yes / No

(CONTINUED ON OTHER SIDE)

Mental health disorders, Specify: _____ Yes / No

Are you being treated for chronic pain? Yes / No

Do you snore? _____ Diagnosed Sleep Apnea? _____ Yes / No

Are you taking blood thinner? Yes / No

Are you taking any medicine(s) including non-prescription drugs? Please list (or we can copy your list):

_____

_____

_____

_____

Women, please circle:

Are you pregnant? Yes / No Are you nursing? Yes / No Taking birth control pills? Yes / No

Chief Dental Complaint: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

DATE: _____ Patient's Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

(Close this window to return to our site).

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 duty, 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 04/14/03, 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 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 and 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 effect 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 to notify, as described in the Patient Rights sections 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 safety or the health of 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 officials 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 $____ 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 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 you complaint with the U.S. Department of Health and Human Services.

Contact Officer: Darenda Platt
Telephone: 228-475-0005 Fax: 228-475-0057
Address: 4400 McInnis Ave., Moss Point, MS 39563
