Welcome to West Side Family Dentistry L.T.D.

Name: _____Date: _____

Date of Birth: _____ ***SS#*** _____ **Drivers License #:**_____
Address: _____ City_____ Zip _____
Home #:_____ Work #: _____Cell #:_____
E-Mail Address: _____
Sex: __Male __Female Marital Status: __Single __Married __Widowed ___Divorced

Employer:_____ Occupation: _____
Referred To Our Office By:_____
Dental Benefits: __Yes __No
Spouse/Significant Other Name:_____

In an emergency, whom should we contact?
Name: _____Ph#_____Relationship:_____

Reason for today's visit? _____

Date of last Dental visit? _____Previous Dentist? _____

Are you currently under medical treatment? __Yes __No Physician's Name?_____
Please explain: _____
_____

Are you taking any medication, including non-prescription and herbal supplements? __Yes __No
Please list them: _____ Reason for taking: _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any of the following:

Yes No		*Yes No*		*Yes No*	
__	__ Use tobacco	__	__ Stomach Troubles/Ulcers	__	__ Use illegal or prescription drugs for nonmedical reasons, i.e. marijuana
__	__ Asthma- Use an inhaler? Yes/ No	__	__ Acid Reflux	__	__ Arthritis
__	__ COPD	__	__ Liver Disease	__	__ Heart Attack- When? _____
__	__ Sinus Problems	__	__ Hepatitis/Jaundice	__	__ Stroke- How Long ago? _____
__	__ Diabetes- Controlled? Yes / No	__	__ Kidney Disease	__	__ Joint Replacement- Knee/Hip Date: _____
__	__ Blood thinner (please list above)	__	__ Hemodialysis	__	__ Radiation Treatment- Head/Neck Location: _____
__	__ Bleed Easily	__	__ Gluten Sensitive	__	__ Osteoporosis– Medication?Yes/ No (please list above) Is this IV medication? Yes/ No
__	__ High Blood Pressure	__	__ Cancer	__	__ Other _____
__	__ Low Blood Pressure	__	__ Thyroid Disorder		
__	__ Cardiac Pacemaker	__	__ Epilepsy/Seizures		
__	__ Angina- Use Nitroglycerin? Yes/ No	__	__ Tuberculosis		
__	__ Heart Murmur	__	__ HIV Infection		
__	__ Mitral Valve Prolapse	__	__ Lupus		
__	__ Artificial Heart Valve	__	__ Sleep Apnea		

Are you allergic to any of the following?

Yes NO		*Yes NO*	
__	__ Penicillin	__	__Aspirin
__	__ Codeine	__	__ Latex
__	__ Sulfa	__	__ Other_____

Women Only

Yes NO	
__	__ Are you taking contraceptives?
__	__ Are you pregnant? Due Date: _____
__	__ Are you nursing?

(**Over)**

Do you have any of the following:

Yes No

__ __ Do your gums bleed when you brush or floss?
__ __ Have you ever noticed an unpleasant taste in your mouth?
__ __ Have you ever experienced gum recession?
__ __ Have you ever had any teeth become loose on their own without any injury?
__ __ Have you experienced a burning or painful sensation in your mouth not related to your teeth?
__ __ Have you had any cavities in the last 3 years?
__ __ Is your mouth dry?
__ __ Are your teeth sensitive to cold, hot, sweets or pressure?
__ __ Have you ever had broken teeth, chipped teeth, or had a toothache or cracked filling?
__ __ Does food or floss catch between your teeth?
__ __ Is there anything about the appearance of your teeth you would like to change?
__ __ Do you have any clicking, popping or discomfort in the jaw?
__ __ Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?
__ __ Do you brux or grind your teeth?
__ __ Have your teeth changed in the last 5 years, become shorter, thinner or worn?
__ __ Are your teeth becoming more crooked, crowded or overlapped?
__ __ Are you teeth developing more spaces or becoming loose?
__ __ Do you chew ice, bite your nails, use your teeth to hold objects, or have any oral habits?
__ __ Do you clench your teeth in the daytime or make them sore?
__ __ Do you have sores or ulcers in your mouth?
__ __ Have you had any periodontal (gum) treatments?
__ __ Do you wear dentures or partials?
__ __ Have you ever had orthodontic (braces) treatment?
__ __ Have you had any problems associated with previous dental treatment?
__ __ Have you ever had a serious injury to your head or mouth?

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation:
0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

_____Sitting and reading
_____Watching TV
_____Sitting, inactive in a public place (e.g. a theatre or a meeting)
_____As a passenger in a car for an hour without a break
_____Lying down to rest in the afternoon when circumstances permit
_____Sitting and talking to someone
_____Sitting quietly after a lunch without alcohol
_____In a car, while stopped for a few minutes in the traffic SCORE: _____

Authorization and release: I have read and understand the above information to the best of my knowledge and have answered the questions accurately. I understand that providing incorrect information can be dangerous to my health. **I authorize and request my insurance carrier to pay directly to the dentist, if applicable. I understand that my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.**

X_____
Signature of Patient or Parent/Guardian

Notice of Dental Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program entitling 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 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 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.

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 and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identifiable 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 in 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 receive an accounting of disclosures of protected health information.
--The right to obtain a paper of this notice from us upon request.

Signed_____Date_____ Patient/Relationship to Patient _____

Signed_____Date_____ Patient/Relationship to Patient _____

Signed_____Date_____ Patient/Relationship to Patient _____

Signed_____Date_____ Patient/Relationship to Patient _____

Signed_____Date_____ Patient/Relationship to Patient _____