New Patient Packet

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: ddg _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: dgd _____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

New Patient Packet

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____

Height: _____ft _____in_____ Weight: _____ Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name: _____ Physician's Phone Number: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

☐ No ☐ Yes How Long? _____

Do you require antibiotics prior to dental procedures? ☐ Yes. ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ **None**

_____

_____

_____

Check any conditions that apply to you :

- ☐ **None**
- ☐ Alcoholism or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Pins Type: Age:
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Tranfusion
- ☐ Breathing Problems
- ☐ Cancer Type:
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes Type:
- ☐ Dialysis
- ☐ Mobility Impairment
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Surgery Date:
- ☐ Heart Trouble Type:
- ☐ Hepatitis Type:
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease/COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Non- Dental Implants Type:
- ☐ Organ Transpants Type:
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis(TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other

New Patient Packet

Dental History

Date of Last Dental Visit:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynaecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature:_____ Date:_____

Dr's Signature/Medical History Review: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

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 duties, 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 January 1, 2023, 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 effective for all health information that we maintain, including health information we created or received before we made the changes.

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 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. Health care 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 health care 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 affect 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, as described in the Patient Rights section 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 Judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment 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 health or safety or the health or 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 official 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 voice mail 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 photo copies.

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 5 years.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information.

Amendment

You have the right to request that we amend your health information. (Your request must be in writing, and it 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 mall (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 support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.

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.

Patient Printed Name : _____

Patient Signature : _____

Date : _____

Broken Appointment Policy

The time the doctor sets aside for a patient is valuable.

Please note that once you have booked an appointment with us it means that we have reserved time in our schedule exclusively for you.
The dental appointment reserved for your care places responsibility on the doctor and the patient. In order to provide quality dental care at an affordable cost these appointments must be kept.

If you cancel your appointment less than **24 hours** before it is scheduled to take place, you will be subject to a fee/rebooking charge of **$75**.

To avoid a cancellation fee, please provide cancellation notice at least **24 hours** prior to your appointment.

You can cancel or reschedule an appointment by emailing us at Hello@acedentalellicottcity.com, texting or calling our office at **410-600-3959**.

Patient Printed Name : _____

Patient Signature : _____

Date : _____