



# River Hills Dental

## Patient Information (Confidential)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

How do you prefer to be reminded of your appointments:

- Home Phone  Cell Phone  Work Phone  E-mail  Text message

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If the patient listed above is not the person responsible for the account, please complete this section:

Name of Responsible Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Is this person a patient in our office?  Yes  No

If patient address above is not the billing address, please complete address line below:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Acknowledgement of Receipt of Notice of Privacy Practices & Authorization for Verbal Communication of Health information

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), River Hills Dental, P.A. must have your specific authorization to share any of your Protected Health information (PHI) with a spouse or family member. This is especially helpful in case there is an urgent need to contact you, if you need to reschedule an appointment and you are not available when we call, if there is someone who assists with your finances, or if someone other than yourself makes appointments for you. These people will not be authorized to disclosure of any of your written health information. You may change or revoke this authorization at any time. Anyone who is financially responsible for your account is entitled to your patient information.

Verbal Communication Regarding my Treatment can be Shared With (please print):

Name and Relationship	Phone Number	Type of Information
_____/_____	_____	<input type="checkbox"/> All <input type="checkbox"/> Limited to: _____
_____/_____	_____	<input type="checkbox"/> All <input type="checkbox"/> Limited to: _____
_____/_____	_____	<input type="checkbox"/> All <input type="checkbox"/> Limited to: _____
_____/_____	_____	<input type="checkbox"/> All <input type="checkbox"/> Limited to: _____

Be signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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  Communication barriers prohibited obtaining the acknowledgment  
 An emergency situation prevented us from obtaining acknowledgment  
 Other (Please Specify) \_\_\_\_\_

**Patient Name** \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

- |  |  |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
|--|--|---|---|--|--|-----------------------------------|--|-----------------------------------|--|---|--|-----------------------------------|--|---------------------------------------|--|---|--|----------------|---------------------------------------|------------------------------------|---|--|---|-----------------------------------|--|-------------------------------------|--|-------------|--|---------|--|-----------|--|--------|--|---------|--|---------------------------------------|--|--------------|--|-------------|--|--|--|------------------|--|-------------------------------------|--|---|--|-----------------------------------|--|---|------------------------------------|--|---------------------------------|---|---|---------------------------------------|--------------------------------------|------------------------------------|---------------------------------------|---|--------------------------------|--|---|--|--------------------------------------|--|--|
| <p>1. Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken any medications for bone loss or osteoporosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have or have you had any of the following?</p> <table border="0"> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Cortisone Treatments</td> </tr> <tr> <td><input type="checkbox"/> Any Type of Cancer</td> <td><input type="checkbox"/> Cough, Persistent</td> </tr> <tr> <td><input type="checkbox"/> Arthritis, Rheumatism</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Artificial Heart Valves</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Artificial Joints</td> <td><input type="checkbox"/> Frequent Headaches</td> </tr> <tr> <td><input type="checkbox"/> Back Problems</td> <td><input type="checkbox"/> Glaucoma</td> </tr> <tr> <td><input type="checkbox"/> Bleeding Disorder</td> <td><input type="checkbox"/> Heart Murmur</td> </tr> <tr> <td><input type="checkbox"/> Blood Disease</td> <td><input type="checkbox"/> Heart Problems</td> </tr> <tr> <td><input type="checkbox"/> Chemical Dependency</td> <td>Describe _____</td> </tr> <tr> <td><input type="checkbox"/> Chemotherapy</td> <td><input type="checkbox"/> Hepatitis</td> </tr> <tr> <td><input type="checkbox"/> Circulatory Problems</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> </table> | <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Any Type of Cancer | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Chemical Dependency | Describe _____ | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <p>9. Are you allergic to or have you had any reactions to the following:</p> <table border="0"> <tr> <td>Local Anesthetics (eg. Novocaine)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Penicillin or any other Antibiotics</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Sulfa Drugs</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Codeine</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Sedatives</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Iodine</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Aspirin</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Any Metals (eg. nickel, mercury etc.)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Latex Rubber</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Other _____</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>10. Women Only:</p> <table border="0"> <tr> <td>Are you pregnant or think you may be pregnant?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Are you nursing?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Are you taking oral contraceptives?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <table border="0"> <tr> <td><input type="checkbox"/> HIV /AIDS Positive</td> <td><input type="checkbox"/> Scarlet Fever History</td> </tr> <tr> <td><input type="checkbox"/> Jaw Pain</td> <td><input type="checkbox"/> Shortness of Breath</td> </tr> <tr> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> Skin Rash</td> </tr> <tr> <td><input type="checkbox"/> Mitral Valve Prolapse</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Nervous Problems</td> <td><input type="checkbox"/> Thyroid Problems</td> </tr> <tr> <td><input type="checkbox"/> Osteoporosis</td> <td><input type="checkbox"/> Tonsillitis</td> </tr> <tr> <td><input type="checkbox"/> Pacemaker</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Psychiatric Care</td> <td><input type="checkbox"/> Ulcer</td> </tr> <tr> <td><input type="checkbox"/> Radiation Treatment</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Respiratory Disease</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic Fever History</td> <td></td> </tr> </table> | Local Anesthetics (eg. Novocaine) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or any other Antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Metals (eg. nickel, mercury etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Rubber | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant or think you may be pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you taking oral contraceptives? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> HIV /AIDS Positive | <input type="checkbox"/> Scarlet Fever History | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Rheumatic Fever History |  |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Cortisone Treatments            |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Any Type of Cancer  | <input type="checkbox"/> Cough, Persistent               |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes                        |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Artificial Heart Valves   | <input type="checkbox"/> Epilepsy                        |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Frequent Headaches              |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Back Problems   | <input type="checkbox"/> Glaucoma                        |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Heart Murmur                    |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Blood Disease   | <input type="checkbox"/> Heart Problems                  |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Chemical Dependency   | Describe _____   |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Chemotherapy  | <input type="checkbox"/> Hepatitis                       |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> High Blood Pressure             |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Local Anesthetics (eg. Novocaine)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Penicillin or any other Antibiotics  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Sulfa Drugs  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Codeine  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Sedatives  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Iodine   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Aspirin  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Any Metals (eg. nickel, mercury etc.)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Latex Rubber   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Other _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Are you pregnant or think you may be pregnant?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Are you nursing?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| Are you taking oral contraceptives?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> HIV /AIDS Positive  | <input type="checkbox"/> Scarlet Fever History           |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Jaw Pain  | <input type="checkbox"/> Shortness of Breath             |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Skin Rash                       |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Stroke                          |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Nervous Problems  | <input type="checkbox"/> Thyroid Problems                |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Tonsillitis                     |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Tuberculosis                    |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Psychiatric Care  | <input type="checkbox"/> Ulcer                           |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease                |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Other _____                     |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |
| <input type="checkbox"/> Rheumatic Fever History   |  |   |   |  |  |                                   |  |                                   |  |   |  |                                   |  |                                       |  |   |  |                |                                       |                                    |   |  |   |                                   |  |                                     |  |             |  |         |  |           |  |        |  |         |  |                                       |  |              |  |             |  |  |  |                  |  |                                     |  |   |  |                                   |  |   |                                    |  |                                 |   |   |                                       |                                      |                                    |                                       |   |                                |  |   |  |                                      |  |  |

## Patient Dental History

- |  |  |  |                                 |  |                                  |  |                       |  |  |
|--|--|--|---------------------------------|--|----------------------------------|--|-----------------------|--|--|
| <p>● Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you feel pain in any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Have you ever experienced any of the following problems in your jaw?</p> <table border="0"> <tr> <td>Clicking</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Pain (joint, ear, side of face)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Difficulty in opening or closing</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Difficulty in chewing</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> | Clicking   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain (joint, ear, side of face) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in opening or closing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>● Does your mouth seem dry at times? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, date of placement _____</p> <p>● Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Clicking   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                       |  |  |
| Pain (joint, ear, side of face)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                       |  |  |
| Difficulty in opening or closing   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                       |  |  |
| Difficulty in chewing  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                       |  |  |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a monthly 1-1/2% finance charge (18% APR) will be added to my account. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.

X \_\_\_\_\_ Signature of patient (or parent if minor) Date \_\_\_\_\_

# Notice of Privacy Practices

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**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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# NOTICE OF PRIVACY PRACTICES

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**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.**

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## **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 April 14, 2003 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. Before we make a significant change in our privacy practices, we will change this 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.

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## **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 or 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 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 healthcare. 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 voicemail messages, postcards, or letters).

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#### 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 \$0.\_\_\_\_\_ 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 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 mail (e-mail), you are entitled to receive this Notice in written form.

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#### 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 your complaint with the U.S. Department of Health and Human Services upon request.

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 Services.

Contact Officer: Jennifer L., Miller

Telephone: (507)452-9453

Fax: (507)452-5420

E-mail: jmiller@riverhillsdental.com

Address: 720 HWY 61 E. Winona, MN 55987

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