Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

General Dentist: _____ Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

Preferred appointment times: ☐ Any Time ☐ Morning ☐ Afternoon ☐ Late ☐ Early ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of my treatment by this office, I understand financial arrangements must be made in advance of treatment. This office accepts cash, personal checks on local banks, money orders, and most major credit cards. I authorize the release of medical records, dental records, and other diagnostics including radiographs to insurance carriers and other professionals participating in my care. I also consent to the release of pictures, video, models, and radiographs taken during the course of my treatment to be used for the advancement of dentistry and/or reimbursement purposes provided my identity is not disclosed. I grant my permission to Dr. Lueder or his assignee, to contact me at home, on my mobile phone, email and/or at my work to discuss matters related to my care.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent, or guardian

JACOB C LUEDER DDS MS
Periodontics and Dental Implants
jclperio.com

HEALTH HISTORY

Please complete the following information to the best of your knowledge
You may leave certain items blank if the information does not apply or is unknown

1. Are you in good health? **yes no**
2. Do you have any allergies? **yes no**
   *List:*_____
   _____
3. Have you ever had a reaction to medications? **yes no**
   Codein, Vicodin, or other opiates **yes no**
   Penicillin **yes no**
   Aspirin or NSAIDS **yes no**
   Iodine **yes no**
   IV drugs **yes no**
   Sulpha drugs **yes no**
   Local anesthetic **yes no**
   Other Medications: _____
   *Describe your reaction:*_____
   _____
4. Are you diabetic? **yes no**
   *Normal blood sugar:*_____ *mg/dL HbA1C:*____ *%*
5. Does anybody in your family have diabetes? **yes no**
6. Do you consume alcohol? **yes no**
   Number of drinks/week: _____
7. Do you smoke or use smokeless tobacco? **yes no**
   Packs/day? _____ *number of years?*_____
   Former smoker? **yes no** quit date:_____
8. What medications do you take?

Drug: _____ *taking for:* _____
Drug: _____ *taking for:* _____
Drug: _____ *taking for:* _____
Drug: _____ *taking for:* _____
Drug: _____ *taking for:* _____
Drug: _____ *taking for:* _____

9. Do you take any over-the-counter medications, vitamins, or supplements (Aspirin, Vit. E, fish oil, etc)? **yes no**
   List: _____
   _____
9. Do you use, or have a history, of illegal drugs? **yes no**
10. Are you under the care of a physician? **yes no**
    Name: _____
    Address: _____
    _____
    Phone: _____
11. Are you being treated by a medical specialist? **yes no**
    What for? _____
    Name: _____
12. Has your health changed in the last year? **yes no**
13. When was your last physical or doctor's visit?
    _____
14. Do you have a tendency to bleed? **yes no**
15. Do you bruise easily? **yes no**
16. Do you have your blood drawn regularly (or in the last 12 months)? **yes no**
    *For what reason?*_____
17. Have you ever been hospitalized, injured, or had major surgery? **yes no**
    Describe: _____
    _____
    _____
18. Are you pregnant or nursing? **yes no**
19. Have you ever had any serious infections? **yes no**
    Describe: _____
20. Have you ever been sedated? **yes no**
    Any complications/adverse reactions? **yes no**
    Describe: _____
21. Do you have, or ever had, any of the following conditions or diseases:
    a. Liver disease or hepatitis **yes no**
    b. Kidney disease **yes no**
    c. Anemia or other blood disorders **yes no**
    d. Thyroid disease **yes no**
    e. Persistent cough (> 3 weeks) **yes no**
    f. Neurological/psychological conditions **yes no**
    g. Depression **yes no**
    h. Epilepsy/Seizures **yes no**
    i. Tendency to faint **yes no**
    j. HIV/AIDS **yes no**
    k. Heart attack **yes no**
    l. Chest pain or angina **yes no**
    m. Stomach problems/ulcers **yes no**
    n. Swollen ankles **yes no**
    o. Frequent urination **yes no**
    p. Sinus problems **yes no**
    q. Skin disease or rash **yes no**
    r. Heart Pacemaker **yes no**
    s. Stroke **yes no**
    t. Cancer **yes no**
    u. Sexually transmitted disease **yes no**
    v. Compromised immune system **yes no**
    w. Delayed or prolonged healing **yes no**
    x. Steroid use **yes no**
    y. Osteoporosis or weak bones **yes no**
    z. Arthritis **yes no**
    aa. Organ transplant **yes no**
    bb. Swollen glands **yes no**
    cc. Severe headaches **yes no**
    dd. Lung disease **yes no**
    ee. Congenital heart defect **yes no**
    ff. Intestinal problems **yes no**
    gg. Asthma **yes no**
    hh. High blood pressure **yes no**
    ii. Low blood pressure **yes no**

CONTINUE TO NEXT SIDE

CONTINUED FROM PREVIOUS SIDE

jj. Heart catheters/stents **yes no**
kk. Take antibiotics for dental treatment **yes no**
ll. Heart infection **yes no**
mm. Radiation or chemotherapy **yes no**
nn. Chronic infection **yes no**
oo. Artificial heart valves **yes no**
pp. Hormone replacement therapy **yes no**
qq. Current pain **yes no**
*(describe):*_____

22. Do you have joint replacements? **yes no**
Location: _____ *for how long:* ____*yrs*
23. Do you take drugs for your bones or cancer? **yes no**
(Actonel, Aredia, Bonefos, Boniva, Didronel, Forteo, Fosamax, Reclast, Skelid, Zometa)
24. Height _____ Weight:_____ Age:_____
25. Are there any other questions, concerns, or information you would like to discuss or that we should be aware of?

_____

_____

DENTAL HISTORY

How do you feel when you come to the dentist (check)?
☐ **Comfortable** ☐ **Somewhat nervous** ☐ **Very anxious**
Are you satisfied with the appearance of your teeth and smile? ☐ **Very much** ☐ **Mostly satisfied** ☐ **No opinion**
☐ **Not satisfied** ☐ **I don't like my teeth or smile at all**
What would you change about your teeth? _____

_____
Have you had complications w/ dental treatment? **yes no**

Does your mouth feel dry? **yes no**
Have you had past dental emergencies? **yes no**
Have you ever had trauma to the mouth or face? **yes no**
Have you had any surgery in your mouth? **yes no**
Do you have noise or discomfort in your jaw joints? **yes no**
Did you have braces? **yes no**
When was your last cleaning? _____
How often do you get your teeth cleaned? _____times/yr
Do/Did any of your family members have gum disease, dentures, or lose their teeth early? **yes no**
Have you ever been told you have gum disease? **yes no**
Have you ever had periodontal treatment or deep cleanings? **yes no** *When?*_____
Are your teeth sensitive to hot/cold or chewing? **yes no**
Are any of your teeth mobile? **yes no**
Do you clench or grind your teeth? **yes no**
Do you have a bite splint you wear at night? **yes no**
Do your gums bleed when you brush or floss **yes no**
Are you concerned about your breath odor? **yes no**
Do you floss or use other dental devices? **yes no**
Do you use mouth rinses? **yes no**
Do you have dental implants? **yes no**
If yes, did you have any compilations? **yes no**
Have you ever had bone grafting in your mouth? **yes no**
Do you have dentures (either partial or complete)? **yes no**
If yes, are you satisfied? **yes no**
Are you concerned about missing teeth? **yes no**
Do you have trouble eating? **yes no**
Do your teeth affect the way you speak? **yes no**
Who is your general dentist? _____
What is the purpose of your initial visit?

_____

_____

Both Doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment.
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 Dr. Lueder and his staff will 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 Dr. Lueder, or any other member of his staff, responsible for any action they take or don't take because of errors or omissions that I may have made in the completion of this form. Further, I authorize for release of information and assignment of benefits relating to my dental/medical insurance.

Patient Name or legal guardian (print) _____

Patient Signature: _____ Date: _____

STOP HERE - TO BE COMPLETED BY YOUR DENTAL PROVIDER

Signature of Provider: _____ Date: _____
This form was updated on: _____ By: _____ Pt Initials:_____
This form was updated on: _____ By: _____ Pt Initials:_____
This form was updated on: _____ By: _____ Pt Initials:_____
Comments: _____
_____
_____
_____
_____

PRECAUTIONS **ASA class:** _____

1	**4**
2	**5**
3	**6**

Changes:_____Date:_____
Changes: Date:

PERIODONTAL IMPLANTICS

Jacob C. Lueder, DDS, MS, PLLC

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Jacob C. Lueder, DDS, MS, PLLC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.jclperio.com or by calling Jacob C. Lueder, DDS, MS, PLLC at (616) 855-4070.

If you have any questions about our *Notice of Privacy Practices*, please contact:

Jacob C. Lueder, DDS, MS, PLLC
Attn: Privacy Officer
2465 Forest Hill Ave. SE
Suite 101
Grand Rapids, MI 49546
(616) 855-4070

I acknowledge receipt of the *Notice of Privacy Practices* of Jacob C. Lueder, DDS, MS, PLLC.

Print Name of Patient:	
Signature of Patient or Representative:	
If Representative, give relationship:	Date:

Jacob C. Lueder, DDS, MS, PLLC

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 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 7.9.09, 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.

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 postcards, emails, letters, or voicemail messages on home, work, and/or mobile phones).

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 $1.00 for each page, $15.00 per hour for staff time to 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.

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: Jacob C. Lueder, DDS, MS

Telephone: (616) 855-4070 Fax: (616) 855-4170

E-mail: jcl@jclperio.com

Address: 2565 Forest Hill Ave. NW, Suite 101, Grand Rapids MI, 49546