Daniel L. Custis, DDS, PC
141 N 5th St
Custer, SD 57730

Patient Name _____ Today's Date _____

Soc Security # _____ Date of Birth _____

Mailing Address _____ Home Telephone _____

911 Address _____ Cell Phone _____

E-Mail Address _____

Business Address _____ Responsible Party _____

DENTAL HISTORY	Y	N
Do you have pain in or near your ears?		
Do you have any unhealed injuries or inflamed areas in or around your mouth?		
Have you experienced any growth or sore spots in your mouth?		
Does any part of your mouth hurt when clenched?		
Have you ever had Novocaine anesthetic?		
Any reactions to allergic symptoms to Novocaine?		
Any difficult extractions in the past?		
Prolonged bleeding following extractions in the past?		
Trench Mouth?		
Do your gums bleed?		
Have you ever had instruction on the correct method of brushing your teeth?		
Have you ever had instruction on the care of your gums?		
Do you chew on only one side of your mouth? If so why?		
Do you at the present time have any dental complaints?		
Do you habitually clench your teeth during the night or day?		
When was your last full mouth X-Ray taken? Where?		
Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? If so locate		

Name of employer _____

Dental Insurance company _____

Person to contact in case of emergency _____

Relationship _____

Home telephone number _____

Business phone number _____

I understand that payment is expected at the time that services are rendered.

_____ _____

Signature Date

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION

Parent/Guardian Marital Status Single Married Separated Widowed Divorced

Please circle one

Mother's Name _____

Address _____

Father's Name _____

Address _____

Guardian's Name _____

Address _____

(605) 673-2011
info@drcustis.com
www.drcustis.com

Daniel L. Custis D.D.S., P.C.
Designing Smiles • Laser Dentistry • CAD/CAM Crowns

MEDICAL HISTORY

FOR

_____ _____

Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Daniel L. Custis, DDS, PC
141 N 5th St
Custer, SD 57730

NOTICE OF PRIVACY PRACTICES

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

Our Facility is committed to protecting and understanding the importance of safeguarding your personal health information. We are required by federal law to maintain the privacy of health information that identifies you or that could be used to identify you (known as "Protected Health Information", and referred to hereafter as PHI). We are also required to provide you with this Notice, which explains our legal duties and privacy practices with respect to PHI that we collect and maintain. This Notice describes your rights under federal law and state law, where applicable, relating to your PHI. We are required by federal law to abide by this Notice. However, we reserve the right to change the Privacy Practices outlined in this Notice and make the new practices effective for all PHI's that we maintain. Should we make such a change, we will display the revised Notice in our facility and make it available to you upon request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Routine Uses and Disclosures of Protected Health Information For Treatment, Payment, or Health Care Operations

Our Facility is permitted under federal law to use and disclose your PHI without your specific permission for three types of routine purposes: treatment, payment, and health care operations.
Our Facility will use or disclose your PHI as described below. Your PHI may be used and disclosed by our staff and others outside of this Facility that are involved in your care and treatment. Set out below are examples of the uses and disclosures of your PHI we are permitted to make for these routine purposes. While this list is not meant to be exhaustive, it should give you an idea of the everyday uses and disclosures "behind the scenes" that are essential to the care you receive.

Treatment. Your PHI can be used and disclosed by this Facility for treatment purposes. For example, your PHI will be used by our Facility to coordinate or manage your dental care and related services. All information is recorded in your dental record, which is necessary for dental providers to determine what treatment you should receive. Dental providers will also record actions taken by them in the coarse of your treatment and note your reactions. We may also disclose your PHI to providers or facilities that may be involved in your care after you leave our facility or care.
Examples of how we will disclose information for treatment may include: referring; hospitals; laboratories; pharmacies.

Payment. Your PHI can be used and disclosed for payment purposes. For example, we may communicate your PHI to your insurance company so that it can process payment for your treatment.

Dental Care Operations. Your PHI can be used and disclosed to allow us to conduct dental care operations, which generally are the administrative activities and to monitor the quality of care after you leave our facility or care.
Examples of how we will used and disclose information: for education and training; to assess services that we may want to offer in the future; to organizations that evaluate, certify or license health care providers.

Other Examples of How This Facility May Use Your Protected Health Information

Advice of Appointment and Services. Our Facility may contact you to provide appointment reminders or information about treatment or information that may be of interest to you. The following appointment reminders may be used: postcard mailed to the address provided by you; telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Family/Friends. Our Facility may disclose to a: family member, friend or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. Our Facility may also use you PHI to notify a family member, a personal representative, or another person responsible for your care, of your location, general health condition or death. In either case, we will exercise our professional judgment and disclose only the PHI that is directly relevant to the person's involvement with your care.

Other Uses and Disclosures of Protected Health Information We May Make Without Your Written Authorization

In general, we are required to obtain your specific written authorization to use or disclose your PHI for purposes unrelated to treatment, payment, or dental/health care operations. However, there are exceptions to this general rule under which we are permitted or required to make certain uses and disclosures of your PHI without authorization. These situations include:

Business Associate. Our Facility may use and disclose PHI to one or more of its business associates if we obtain satisfactory written assurances, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists our Facility in undertaking some essential function, such as a billing company that assists our Facility in submitting claims for payment.

Personal Representative. We may use and disclose your PHI to a person who has the authority to represent you in making decisions related to your health care.

Emergency Situations. We may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your consent as soon as possible. We may also use and disclose PHI to a public or private entity, authorized by law or its charter to assist in disaster relief, for the purpose of coordinating your care.

Required by the Health and Human Services. We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with federal privacy law.

Required by Law. We may use or disclose you PHI to the extent that the use or disclosure is otherwise required by state or federal law.

Public Health. We may disclose your PHI when requires by law to provide information to a public health authority to prevent or control disease.

Abuse or Neglect. If you have been a victim of abuse, neglect, or domestic violence, we may disclose your PHI to the government agency authorized to receive such information.

Health Oversight. When authorized by law, we may disclose your PHI to a health oversight agency. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include audit, investigations, inspections, and licensure.

Judicial and Administrative Proceedings. We may use and disclose PHI in response to a court order or a lawfully issued subpoena.

Law Enforcement. We may disclose your PHI to a law enforcement agency, such as providing information to police about the victim of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI to a coroner, medical examiner, or a funeral director if it is needed to carry out their duties.

Research. We may disclose your PHI to researchers when the research is being conducted under established protocols to ensure the privacy of your information.

Serious Threat to Health and Safety. We may disclose your PHI if we believe it is necessary to prevent a serious and imminent threat to the public health or safety and it is to someone we reasonably believe is able to prevent or lesson the threat.

Daniel L. Custis, DDS, PC
141 N 5th St
Custer, SD 57730

Acknowledgement of Receipt of Notice of Privacy Practices

Patient or Subscriber Name:_____
(Please print name)

I,_____,
(Print name of person signing below)
Acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which our office may use or disclose Personal Health Information to provide service, by Dr. Daniel Custis and Staff.

Signed:_____ Date:_____ Initial if family exempt ____

If not signed by patient, please indicate relationship:_____

NOTE : Parents must have legal custody. Legal guardians and conservators must show proof.

This section to be filled out only by Dr. Custis's Office

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgement of Receipt because:

[] Patient left office before Acknowledgement could be signed

[] Patient does not wish to sign this form.

[] Patient cannot sign this form because:_____

Patient did not receive the Notice of Privacy Practices because:

[] Patient required emergency treatment.

[] Patient declined the Notice and signing this Acknowledgement.

[] Other:_____

Name:_____
(Print name of provider or provider's representative)

Signed:_____ Date:_____
(Signature of provider or provider's representative)