• DENTAL PATIENT INFORMATION FORM •

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Patient's Name _____ Male__ Female__ Today's Date _____
Nickname/Preferred Name (if any) _____ Birth Date _____ SS# _____
Status □ *child* Adult □ *single* □ *married* □ *divorced* □ *widowed* Guardian/Spouse's Name _____
Billing Address _____ City/State _____ Zip _____
Home Phone _____ Cell Phone: _____
Email Address _____ Best time/phone # to reach you at is? _____

EMPLOYMENT

Employer _____ Job Title _____
Work Phone _____ May we call you at work? _____

DENTAL INSURANCE

Subscribers Name _____
Relationship to Patient _____ Birth Date _____
Employer _____ Group # _____
SSN/Insurance ID _____
Insurance Company _____
Insurance Phone # _____

SECONDARY INSURANCE *(IF APPLICABLE)*

Subscribers Name _____
Relationship to Patient _____ Birth Date _____
Employer _____ Group # _____
SSN/Insurance ID _____
Insurance Company _____
Insurance Phone # _____

I authorize Bird & Wittenberg Dental Partnership to release any patient record information needed to process benefit claims for myself or for my dependents and to submit claims on my (or their) behalf. I also authorize insurance payments to be issued from my insurance company directly to Bird & Wittenberg Dental Partnership.

X SIGNATURE *(patient, parent or guardian)* _____ Date _____

I authorize Bird & Wittenberg Dental Partnership staff to discuss my dental and account information with my spouse, guardian, parent or significant other.

X SIGNATURE *(patient, parent or guardian)* _____ Date _____

DENTAL HISTORY

Name of previous dentist _____ Last dental visit _____ Date of last x-rays _____
How often do you brush? _____ Floss? _____ Whiten teeth? _____ Other? _____

ARE YOU CONCERNED WITH ANY OF THE FOLLOWING?

□ Prevention of decay
□ Mouth odor
□ Replacing old mercury/silver fillings
□ Appearance of smile
□ Chipped/worn teeth
□ Recurring/untreated gum disease
□ Color of your teeth
□ Replacing missing teeth
□ Other _____

PLEASE CHECK ALL THAT APPLY

□ Dry mouth/Sjogrens Disease
□ Tooth sensitivity
□ Bleeding gums
□ Periodontal treatment/disease
□ Chronic headaches
□ TMJ soreness/pain
□ Jaw clicking/popping
□ Grind/clench teeth
□ Sore/tired jaw muscles
□ Removable denture/partial/bridge
□ Dental implants
□ Active tooth decay
□ Does food catch between your teeth?
□ Do you wear a night guard?

Have you had trouble associated with any previous dental treatment? _____
Do you require Pre-medication for dental appointments? □yes □no
If yes, please list associated condition _____

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MEDICAL HISTORY

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician/Medical Clinic_____ Phone # _____ Date of last physical exam_____

Emergency Contact_____ Relationship_____ Phone # _____

PLEASE CHECK IF YOU ARE ***ALLERGIC*** TO ANY OF THE FOLLOWING

☐ Local anesthetics ☐ Aspirin ☐ Latex sensitivity ☐ Barbiturates, sedatives, sleeping pills ☐ Codeine ☐ Sulfa drugs
☐ Shellfish, iodine, red wine ☐ Metal ☐ Acrylic ☐ Penicillin/other antibiotics ☐ Other_____

Are you currently taking any Prescription Medications? ☐ Yes ☐ No
If yes, please list names & dosages if known _____

Are you currently taking any Bisphosphonates for Osteoporosis? ☐ Yes ☐ No
If yes, please list names & dosages if known _____

Are you currently taking any Non Prescription Medications? i.e. Aspirin, Ibuprofen, Vitamins etc ☐ Yes ☐ No
If yes, please list names & quantity/frequency taken _____

Women only: Pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Oral Contraceptives? ☐ Y ☐ N Hormone replacement? ☐ Y ☐ N

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? CHECK ALL THAT APPLY

☐ AIDS or HIV Infection
☐ Anemia
☐ Angina
☐ Arthritis
☐ Artificial (prosthetic) Heart Valve
☐ Artificial Joint Replacement
☐ Asthma
☐ Autoimmune Disease
☐ Cancer/Chemotherapy/Radiation
☐ Chest Pain upon Exertion
☐ Depression
☐ Diabetes Type I or II
☐ Drug Addiction/Use
☐ Emphysema/Lung Disease
☐ Epilepsy or Seizures
☐ Fainting Spells
☐ G.E. Reflux/Persistent Heartburn
☐ Heart Attack
☐ Pacemaker
☐ Heart Murmur
☐ Hepatitis A
☐ Hepatitis B/C
☐ High Blood Pressure
☐ Hypoglycemia
☐ Kidney Problems
☐ Leukemia
☐ Low Blood Pressure
☐ Migraines/Severe Headaches
☐ Mitral Valve Prolapse
☐ Rheumatic Fever
☐ Sinus Trouble
☐ Sleep Disorder/Apnea/Snoring
☐ Smoke/Use Tobacco *If yes, type*_____
☐ Stroke
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers

Have you ever had any serious illness or condition not listed? _____

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 the patient's health. It is my responsibility to inform the dental office of any changes in medical status.**

X SIGNATURE *(patient, parent or guardian)*_____ Date_____ Dr review_____

UPDATE & REVIEW

DATE_____ X SIGNATURE *(patient, parent or guardian)*_____ CLINICIAN INITIALS_____
DATE_____ X SIGNATURE *(patient, parent or guardian)*_____ CLINICIAN INITIALS_____
DATE_____ X SIGNATURE *(patient, parent or guardian)*_____ CLINICIAN INITIALS_____

BIRD & WITTENBERG
DENTAL PARTNERSHIP
est. CO. SPRINGS, CO 1990

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT •

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Print Name Date

_____

Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment 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)

_____

_____

_____

BIRD & WITTENBERG
DENTAL PARTNERSHIP
est. CO. SPRINGS, CO 1990

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 laws 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 4 / 14 / 03 , 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use of 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).

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 maybe also request access by sneding us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $10 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 ot 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

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 may also 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	Dr. Edd Wittenberg
TELEPHONE	(719) 593-0403
FAX	(719) 593-0767
EMAIL	birdwittenberg@frii.com
ADDRESS	7222 Commerce Center Dr., Suite 247
	Colorado Springs, CO 80919