

Patient Information Form

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____
Last First Mi Mr, Mrs, Ms, Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: _____

SS #: _____

Home Address: _____ Apt #: _____

City: _____ State: ____ Zip: _____

Single Married Divorced Widowed Separated

Home #: (____) _____ Pager / Cell #: (____) _____

Work #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How Long There? _____ Occupation: _____

Where & When are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

(Please circle)

Last Visit Date: _____

Work#: (____) _____ Home #: (____) _____

Spouse Information

His / Her Name: _____

Employer: _____

Work #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Person Responsible for Account: _____

Work #: (____) _____ Ext: ____ Home#: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Work #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please Explain: _____

Your current physical health is: Good Fair Poor

Taking prescription or over-the-counter drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N Anemia / Radiation Treatment	Y N Hemophilia / Abnormal Bleeding
Y N Artificial Bones / Joints / Valves	Y N Hepatitis
Y N Arthritis	Y N High / Low Blood Pressure
Y N Asthma	Y N HIV+ / AIDS
Y N Blood Transfusion	Y N Hospitalized for any reason
Y N Cancer / Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Rheumatic / Scarlet Fever
Y N Drug / Alcohol Abuse	Y N Severe / Frequent Headaches
Y N Emphysema / Glaucoma	Y N Shingles
Y N Epilepsy / Seizures / Faint Spells	Y N Sickle Cell Disease / Traits
Y N Fever Blisters / Herpes	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers / Colitis
Y N Heart Surgery / Pacemaker	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry / Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs / materials that you are allergic to: _____

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No

If so, when? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Personal Dental Needs Survey

One of the goals of our office is to always understand and meet the needs of our patients. We want your visits to our office to be exceptional experiences. The comfort and quality of care you receive here are among our highest priorities.

Name: _____ Date: _____

Please rate what is most important to you (the most important would be #1)

_____ Show me what he is doing or needs to do so I can clearly understand what is happening.

_____ Listen to my concerns and explain thoroughly the procedures to be performed.

_____ Make sure I feel comfortable and informed at all times.

In a few words, tell us about your past dental history _____

Were there any complications? _____

What have you especially liked about your previous dental offices? _____

What would you like to change, if anything, about the appearance of your teeth?
(Whiter / Straighter / Longer / More Even / Close Spaces / Other?

Are any of your teeth sensitive to: Hot () Cold () Sweets () Pressure ()

Have you ever had:

Orthodontic Treatment (Braces) No () Yes ()

Oral Surgery (Including Wisdom Teeth Removal) No () Yes ()

Your bite adjusted No () Yes ()

Wore a bite plate/ nightguard No () Yes ()

Have you noticed:

Loosening of your teeth No () Yes ()

Food catching between your teeth No () Yes ()

Pain / Swelling of your gums No () Yes ()

Bad breath No () Yes ()

Sore areas in your mouth No () Yes ()

Have you experienced:

Clicking of the jaw No () Yes ()

Difficulty in opening/ closing No () Yes ()

Difficulty chewing No () Yes ()

Do you:

Clench or grind your teeth No () Yes ()

Breathe through your mouth while you sleep No () Yes ()

Is there anything else you would like us to know about your care and treatment in our office?

Brook Park Dental

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 (4/15/2003), 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.

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).

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 \$30.00 per set 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.

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: Dr David Blackley

Telephone: 268-9777

Address: 6430 Brook Park Dr
Colorado Springs, CO 80918

Brook Park Dental
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please Print Name}

{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)