Sussex Family Dental

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As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT INFORMATION

Patient's First Name: _____ Middle Initial: _____ Last Name: _____

Sex: _____ Marital Status: _____ Date of Birth: _____ SSN: _____

Patient's Address: _____ Unit/Apt/Fl: _____

City: _____ State: _____ Zip Code: _____ Referred By: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

If you are completing this form for another person…your name: _____ Relationship: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relation to Patient: _____

Do you have any of the following diseases or problems? (Check "DK" if you do not know the answer to the question)

	YES	NO	DK
Active tuberculosis	□	□	□
Persistent cough greater than a 3 week duration	□	□	□
Cough that produces blood	□	□	□
Been exposed to anyone with tuberculosis	□	□	□

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

BILLING AND INSURANCE

Primary Dental Insurance

Insurance Company: _____ Insured's Employer/School: _____

Plan Type: □ HMO □ PPO □ Medicaid Plan #: _____ Group #: _____ ID #: _____

Insured's Name: _____ Relation to Patient: _____

Insured's DOB: _____ Insured's SSN: _____ Insured's Phone #: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance Company: _____ Insured's Employer/School: _____

Plan Type: □ HMO □ PPO □ Medicaid Plan #: _____ Group #: _____ ID #: _____

Insured's Name: _____ Relation to Patient: _____

Insured's DOB: _____ Insured's SSN: _____ Insured's Phone #: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Reason for Visit

What brings you to the office today: _____

DENTAL INFORMATION

When was your last dental exam? _____

When were your last dental x-rays taken? _____

How often do you brush? # times/day _____

How often do you floss? # times/day _____

Do you grind your teeth? □ Yes □ No □ DK

Have you ever had orthodontic (braces) treatment? □ Yes □ No

Have you ever had periodontal (gum) treatments? □ Yes □ No

Do you have any of the following?

□ Bad breath	□ Bleeding Gums	□ Blisters on Mouth
□ Broken Fillings	□ Clicking Jaw	□ Dentures
□ Dry Mouth	□ Ear Pain	□ Jaw Pain
□ Loose Teeth	□ Mouth Pain	□ Mouth Sores
□ Partials	□ Sensitivity to Cold	□ Sensitivity to Heat
□ Sensitivity to Sweets	□ Sensitivity to Pressure	□ Swollen Gums

MEDICAL HISTORY

Please mark (X) your response to indicate if you have or have not had any of the following disease or problems. Mark "DK" if you do not know.

	YES	NO	DK
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, date: _____ What? _____	□	□	□
Are you currently taking blood thinners? If yes, which? _____ Strength/Dose: _____ When did you start taking them? _____	□	□	□
Allergies: Are you allergic to or have you had a reaction to: To all **YES** responses, please specify type of reaction.	**YES**	**NO**	**DK**
Local anesthetics _____	□	□	□
Do you use controlled substances (drugs)?	□	□	□
Do you use tobacco products?	□	□	□
Do you drink alcoholic beverages?	□	□	□
WOMEN ONLY: Are you……			
Pregnant?	□	□	□
Number of weeks: _____			
Taking birth control?	□	□	□
Nursing?	□	□	□
	YES	**NO**	**DK**
Metals _____	□	□	□
Latex (rubber) _____	□	□	□

Aspirin _____	□	□	□	Iodine _____	□	□	□
Penicillin (or other antibiotic) _____	□	□	□	Hay fever/seasonal _____	□	□	□
Barbiturates, sedatives _____	□	□	□	Animals _____	□	□	□
Sulfa drugs _____	□	□	□	Food _____	□	□	□
Codeine or other narcotics _____	□	□	□	Other _____	□	□	□

PLEASE MARK (X) YOUR RESPONSE TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

	YES	NO	DK		YES	NO	DK		YES	NO	DK
Cardiovascular disease	□	□	□	Mitral valve prolapse	□	□	□	Autoimmune disease	□	□	□
Angina	□	□	□	Pacemaker	□	□	□	Rheumatoid arthritis	□	□	□
Arteriosclerosis	□	□	□	Rheumatic fever	□	□	□	Systemic lupus erythematosus	□	□	□
Congestive heart failure	□	□	□	Rheumatic heart disease	□	□	□	Asthma	□	□	□
Damaged heart valves	□	□	□	Abnormal bleeding	□	□	□	Bronchitis	□	□	□
Heart attack	□	□	□	Anemia	□	□	□	Emphysema	□	□	□
Heart murmur	□	□	□	Blood transfusion	□	□	□	Sinus trouble	□	□	□
Low blood pressure	□	□	□	If yes, date: _____				Tuberculosis	□	□	□
High blood pressure	□	□	□	Hemophilia	□	□	□	Cancer/Chemotherapy/Radiation	□	□	□
Other congenital heart defects	□	□	□	AIDS / HIV infection	□	□	□	Chest pain upon exertion	□	□	□
Chronic pain	□	□	□	Diabetes Type I or II	□	□	□	Eating disorder	□	□	□
Malnutrition	□	□	□	Gastrointestinal disease	□	□	□	GE Reflux/heartburn	□	□	□
Ulcers	□	□	□	Thyroid problems	□	□	□	Stroke	□	□	□
Glaucoma	□	□	□	Hepatitis, liver disease	□	□	□	Epilepsy	□	□	□
Fainting spells, seizures	□	□	□	Neurological disorders	□	□	□	Sleep disorder	□	□	□
Mental health disorders	□	□	□	Recurrent infections	□	□	□	Kidney problems	□	□	□
Night sweats	□	□	□	Osteoporosis	□	□	□	Persistent swollen glands in neck	□	□	□
Severe headaches/migraines	□	□	□	Severe/rapid weight loss	□	□	□	Sexually transmitted disease	□	□	□

Other: _____

	YES	NO	DK
Are you taking or have you taken any prescription or over the counter medicine(s)?	□	□	□

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all pertinent patient 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 my dentist and his/her 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 my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors and emissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

HIPPA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health or condition and related health care services. 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 directly.

Uses and Disclosures of Health Information

We will use and disclose your Protected Health Information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination of management of your healthcare with a third party. For example, your Protected Health Information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

- Your Authorization
  - Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice. 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.
- Payment
  - Your health information will be used, as needed, to obtain payment for your health care services.
- 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 involved in your treatment to the extent necessary to help with your healthcare.
- Persons Involved in Care
  - 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.
- Required by Law
  - We may use or disclose your health information when we are required to do so by law.
- Healthcare Operations
  - We may use or disclose, as needed, your health information to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, licensing, or conducting and arranging for students to see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your health information, as necessary, to contact you to remind you of your appointment.
  - We may use or disclose your health information in the following situations without your authorization. These situations include: as required by law: public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings,

law enforcement, coroners, funeral directors, and organ donation; research; criminal activity, military activity, national security, workers compensation when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with these requirements.

Patient Rights

- Access
  - You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed in this notice for assistance in reaching the providers or staff.
- Disclosure Accounting
  - You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 (six) years.
- Restriction
  - You may 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).

Questions and Complaints

You have the right to complain to the Secretary of Health and Human Services or to us if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions to this form, please ask to speak to our HIPPA compliance officer in person or by phone at our main phone number.

Your signature below is an acknowledgement that you have received this notice of our privacy practices.

Patient Name (print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

Request for Confidential Communications

Name of Patient: _____ Date of Birth: _____

1. Written communications:

Address to: _____

_____

Email address: _____

If the address provided is not our home address or is not a street or is not a street address, please provide us with a street address for purposes of ensuring payment

2. Oral communications:

Home #: _____ Leave message? □ YES □ NO

Work #: _____ Leave message? □ YES □ NO

Cell #: _____ Leave message? □ YES □ NO

May we send text message reminders?: □ YES □ NO

******OFFICE USE ONLY********

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Reason: _____ Initials: _____