HERWIG DDS

Today's Date: _____

Patient Name:	DOB:	Social Security No:
Home Address:	City, State, Zip:	Home Phone:
Email Address:	Marital Status:	Cell Phone:

Responsible Party

Responsible Party Name:	DOB:	Social Security No:
Home Address:	City, State, Zip	Home Phone:
Marital Status:	Relationship to Patient	Cell Phone:
Responsible Person's Employer:	Occupation:	Work Phone:
Business Address:	City, State, Zip	
Spouse's Name:	Social Security No:	Spouse's DOB:
Spouse's Employer:	Spouses Occupation:	Spouse's Work Phone:
Spouse's Business Address:	City, State, Zip	

If you were referred, whom may we thank for referring you? _____

If you were NOT referred, how did you hear about our office? _____

HERWIG DDS

MEDICAL AND DENTAL HISTORY

What is the reason for your visit today? _____

Previous Dentist(s): _____ Last Visit: _____ Date of last Cleaning: _____

What problems, if any, did you have with your past dental treatment: _____

Are you nervous about seeing the dentist? Yes No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(Please circle each)

Y N My dental care has been IRREGULAR in the past 5 years?
Y N I clench or grind my teeth during the day or while I sleep
Y N My gums bleed while brushing or flossing
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N Have you had Periodontal (gum) treatment?
Y N Does your jaw Pop or Click?
Y N I have sensitive teeth
If yes, are you sensitive to which of the following? Hot Cold Sweets Other: _____
Y N I have problem eating
Y N I have had braces
Y N I like my smile
Y N I want my teeth whiter
Y N Do you have bad breath
Y N I have a sore jaw

I consider my health to be: **Poor** **Fair** **Good** **Excellent**

Do you have any of the following? Please circle **Y** for yes or **N** for no

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure High or Low
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Sexual Transmitted/Venereal Disease
11. Y N Kidney Disease
12. Y N Tumor or Malignancy
13. Y N Cancer/Chemotherapy
14. Y N Liver Disease
15. Y N Jaundice
16. Y N Hepatitis Type _____
17. Y N Diabetes
18. Y N Excessive Urination
19. Y N Infectious Mono
20. Y N Herpes
21. Y N Arthritis
22. Y N Asthma
23. Y N Hay Fever
24. Y N Sinus Trouble
25. Y N Epilepsy/Seizures
26. Y N History of drug addiction
27. Y N Radiation Treatment
28. Y N Implants/Artificial Joints:
When? a. Hip_____ b. Knee_____ c. Other_____
29. Y N Immune Suppressed Disorder
30. Y N Fainting Spells?
31. Y N History of emotional or nervous disorders?
32. Y N I usually take an antibiotic prior to dental treatment
What for_____
_____
33. Y N I smoke or use tobacco.
If yes; how much per day _____
How many years _____
34. Y N Major Surgery:
Year: _____
Type: _____
35. Y N Are you fatigued?

HERWIG DDS

MEDICAL AND DENTAL HISTORY

36. Y N Do you have excessive daytime sleepiness?
37. Y N Do you snore?
38. Y N Do you have morning headaches?
39. Y N Do you have any other medical problems or medical history NOT listed on this form?
40. Y N Ulcers
41. Y N AIDS
42. Y N Hearing Loss
43. Y N Glaucoma

WOMEN

Y N Are you taking birth control medication?

Y N Are you or could you be pregnant or nursing?

Are you **allergic** to any of the following?

Y N Aspirin

Y N Ibuprofen

Y N Sulfa/Sulfites/Sulfides

Y N Penicillin

Y N Codeine

Y N Latex/Metals/Plastics

Y N Other medications? _____

Please list all medications you are currently taking:

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Physicians' Name: _____ Phone: _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CONSENT

I have answered all of the above health questions to the best of my abilities and knowledge. I hereby authorize the doctor(s) and staff of HERWIG DDS to perform dental services upon the aforementioned patient(s).

Signature: _____ Date: _____ Relationship to Patient: _____

HERWIG DDS

INSURANCE INFORMATION

Primary Insurance: _____ Group: _____ Relationship to Patient: _____

Secondary Insurance: _____ Group: _____ Relationship to Patient: _____

Patient Name:
Insurance Carrier Name:
Insurance ID#:
Group #:
Insurance Phone Number:

Policy Holder Name:
Policy Holder DOB:
Policy Holder SSN:

Effective Date:
Relationship to Patient:

FINANCIAL POLICY

As a service to our patients First Pacific Corporation (FPC), our billing company, files PPO dental insurance on your behalf. We request your cooperation in contacting your insurance company if the payment for treatment rendered is not received within 60 days. Your insurance is a contract between you and your insurance company, not between the insurance company and our office. We will help to the best of our knowledge and abilities; however, our office cannot know all of the limitations or exclusions that are involved in your particular insurance plan. It is your responsibility to inform us of any changes in order to effectively expedite your insurance claims. Ultimately, you are responsible for the balance on your account.

I have read and am in agreement with the financial policy stated above.

Signature of Responsible Party: _____ Date: _____

HERWIG DDS

Cancellation/No Show Policy

Successful dental care is dependent upon the patient keeping their scheduled appointment.

We understand that emergencies and schedule conflicts will happen. Your cooperation in giving us advanced notice gives us the opportunity to allow other patients to come at your appointment time.

If for any reason you cannot make your appointment, please give us advanced notice. We ask that at least 24 hour notice be given when possible. If you do not show for an appointment or do not call within 24 hours to cancel, a fee of $35.00 will be charged at our discretion. Any late arrival more than 15 minutes may result in a cancellation of appointment.

Please sign below to indicate that you have read and understand our cancellation/no show policy.

Patient/Guardian Signature:_____

"**Invest** in **yourself**. It will pay you for the *rest of your life.*"
- Anonymous

HERWIG DDS

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 03/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 practice, 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 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 filling 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 officials having lawful custody of protected health information of an 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 practically 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 $25.00 for each page, $.25 per hour 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 at the end of this Notice for a full explanation or 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 for 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 may 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 of 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 to 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 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:_____

Telephone:_____Fax:_____

E-mail:_____

Address:_____

_____

HERWIG DDS

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.

_____
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)

_____

_____

_____