Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: _____ Family Status:_____

Social Security #: _____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

General	**Heart/ Blood Vessels**	**Blood**	**Dental History**
• Tire Easily	• Rheumatic Fever	• Bruise easily	Mouth:
• Marked Weight Change	• Heart Murmur	• Anemia	• Bleeding/Sore Gums
• Night Sweats	• Chest Pain/ Discomfort	• Blood transfusion	• Burning Tongue/ Lips
Nervous System	• Heart Attack	**Other**	• Frequent Blisters
• Stroke	• Shortness of breath	Autoimmune	Teeth:
• Headache	• Swelling of ankles	• HIV/ AIDS	• Loose Teeth
• Convulsions/Epilepsy	• High Blood Pressure Last Reading BP:_____	• Arthritis/ Rheumatism	• Sensitive to hot/cold/sweet
• Numbness/Tingling	• Congenital Heart Disease	• Lupus	• Sensitive to Biting
• Dizziness/Fainting	• Mitral Valve Prolapse	• Any Other Autoimmune	• Food impaction
• Psychiatric Treatment	• Artificial Heart Valve	• Cancer	• Clenching
Respiratory	• Pacemaker	• Radiation Therapy	• Shifting of teeth
• Tuberculosis	• Heart Surgery	• Chemotherapy	• Bite changing
• Emphysema	• Other Heart Conditions	• Hip/Knee Replacement	• TMJ:
• Asthma	**Urinary**	• Chronic Sinus Problems	• Pain
• Persistent Cough	• Kidney Disease	• Prior use of diet drugs	• Clicking or popping
• Difficulty Breathing	• Increase frequency of urination (night)	• Other Relevant information	• Difficulty opening or closing jaw

•Have you been admitted to a hospital or needed emergency care? ☐ Yes ☐ No
If yes, please explain: _____

•Are you currently or have you ever taken a Osteoporosis Drugs? (Fosamax, Alendronate etc) ☐ Yes ☐ No

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Are you currently taking any medications and for what? ☐ Yes ☐ No

Medication:	**Reason:**
_____	_____
_____	_____
_____	_____
_____	_____

• Are you taking any anticoagulants (blood thinners)? Are you taking aspirin on a regular basis? ☐ Yes ☐ No

• Are you ALLERGIC or have you ever experience any reaction to the following? ☐ Yes ☐ No

☐ Penicillin	☐ Latex	☐ Asprin
☐ Sulfa drugs	☐ Local Anesthetics	☐ Other Medications

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation: _____

Address: _____.
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party or of payment/responsible party

METROPOLITAN PERIODONTICS
periodontics • implant dentistry

NOTICE OF PRIVACY PRACTICE

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: April 14, 2003

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION
The following categories describes different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our stuff in caring for you.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT YOUR CONSENT OF AUTHORIZATION.
- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health of safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or a medical examiner for identification of a body
- If an inmate, the correctional institution or a law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosure required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRINF YOUR WRITTEN AUTHORIZATION
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

YOU INDIVIDUAL RIGHTS REGUARDING
- **DISCLOSURES AND CHANGES TO YOUR MEDICAL INFORMATION**

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose

about you for treatment, payment or health care operations or to someone who is involved on your care or the payment of your care. We
are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

RIGHT TO ACCOUNT 0F NON-STANDART DISCLOSURES. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want you receive a list of disclosures that is no longer than six years, and may not include dates before April
(Example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing list.

RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request and

amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not created by us, is not part of medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

- **YOUR ACCESS TO MEDICAL INFORMATION**

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes; information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy
medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

RIGHT TO REQUEST CONFIDENT COMMUNICATION. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filling a complaint.

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to the protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations describes in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

CHANGES TO THIS NOTICE
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.