

Welcome!

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss? _____

Date of Last Dental Visit _____

How Often Do You Brush? _____

Please check all that apply:

- Bad Breath
- Bleeding Gums
- Blisters on Lips or Mouth
- Finger Nail Biting
- Grinding Teeth
- Lip or Cheek Biting

- Loose Teeth or Broken Fillings
- Orthodontic Treatment
- Pain Around Ear
- Periodontal Treatment
- Sensitivity to Cold
- Sensitivity to Heat

- Sensitivity to Sweets
- Sensitivity When Biting
- Frequent Headaches
- Jaw, Head or Neck Injuries
- Jaw Difficulty: Clicking and/or Pain..
- Tooth Pain

Medical History

Physician's Name _____ Date of Last Visit _____

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

7. Have you had any allergic reactions to the following:

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please describe: _____

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |

8. (Women Only) Are You:

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- AIDS
- Anemia.....
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Bleeding abnormally, with extractions or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Chronic Fatigue Syndrome
- Circulatory Problems
- Congenital Heart Lesions.....
- Cortisone Treatments
- Cough - persistent or bloody...
- Diabetes.....

- Emphysema
- Epilepsy
- Fainting or Dizziness
- Glaucoma
- Headaches.....
- Heart Murmur
- Heart Problems.....
- Hepatitis-Type _____
- Herpes.....
- High Blood Pressure
- HIV Positive
- Jaundice
- Jaw Pain
- Kidney Disease
- Latex Sensitivity
- Liver Disease.....
- Low Blood Pressure
- Mitral Valve Prolapse.....
- Nervous Problems.....

- Pacemaker.....
- Psychiatric Care
- Radiation Treatment.....
- Respiratory Disease.....
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble.....
- Skin Rash
- Stroke
- Swelling of Feet/Ankles.....
- Swollen Neck Glands.....
- Thyroid Problems.....
- Tonsillitis
- Tuberculosis.....
- Tumor or growth on head/neck.....
- Ulcer.....
- Venereal Disease

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are not permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you.

We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the

custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Matlock Dental Care
301 NE Mulberry St #205
Lee's Summit, MO 64086
(816) 246-4920

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775



MatlockDentalCare

— PAUL T. MATLOCK DDS —

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Thank you for choosing Matlock Dental Care for your dental care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our Administrative Team to acknowledge that you have been provided a copy of our Notice.

As stated in the Notice of Privacy Practices, our practice will only disclose private health information directly relevant to his/her involvement with your health care, private health information related to payment of your health care, and private information used for notification purposes based on your releases below. Our practice may release your private health information to another party that you identify that is involved in your care.

It is your option to list people with whom we can discuss your care and leave messages:

	Name	Relationship	Telephone Number
Dental			
Billing			

I ACKNOWLEDGE: A copy of the Notice of Privacy Practices for Matlock Dental Care was given to me.

Signature of Patient (or Legal Representative)

Date

Print Name

Patient Date of Birth

Signature of Team Member(Office Use Only)

Date