DAVENPORT
DENTAL GROUP

Name: _____ **Date of Birth:** _____

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.		
Have you or your child had any of the following diseases or problems?	**YES**	**NO**
Active tuberculosis	❑	❑
Persistent cough greater than 3 week duration	❑	❑
Cough that produces blood	❑	❑

	YES	NO
1. Are you in good health?	❑	❑
2. Has there been any change in your general health within the past year?	❑	❑
3. Are you now under the care of a physician?	❑	❑

If yes, what is/are the condition(s) being treated:

_____

_____

_____

_____

4. Date of last physical examination:

_____

Physician's Name(s):

_____

_____

_____

_____

5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ❑ ❑

If yes, what was the illness or problem?

_____

_____

_____

_____

6. Please (X) a response to indicate if you have or have not had any of the following diseases or problems:

	YES	NO
Abnormal bleeding	❑	❑
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Anxiety	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Blood transfusion	❑	❑
If yes, date of transfusion: _____		
Cancer, chemotherapy/radiation treatment	❑	❑
Cardiovascular disease:	❑	❑

If yes, specify below:

- ❑ *Artificial heart valves*
- ❑ *Congenital heart defect*
- ❑ *Coronary artery disease*
- ❑ *Damaged heart valves*
- ❑ *Heart attack*
- ❑ *Heart Murmur*
- ❑ *Heart surgery*
- ❑ *High blood pressure*
- ❑ *Low blood pressure*
- ❑ *Mitral valve prolapse*
- ❑ *Pacemaker*
- ❑ *Rheumatic fever/ Rheumatic heart disease*

Depression	❑	❑
Diabetes	❑	❑
Disease, drugs or radiation induced immunosuppression	❑	❑
Epilepsy	❑	❑
Fainting spells or seizures	❑	❑
G.E. Reflux/persistent heartburn	❑	❑
Hemophilia	❑	❑
Hepatitis	❑	❑
Liver disease	❑	❑
Mental disorder	❑	❑
Kidney problems	❑	❑
Osteoporosis	❑	❑
Respiratory problems	❑	❑
❑ *Emphysema* ❑ *Bronchitis*		
Sever headaches/migraines	❑	❑
Sinus trouble	❑	❑
Stroke	❑	❑
Systemic lupus erythematosus	❑	❑
Thyroid problems	❑	❑
Tuberculosis	❑	❑
Ulcers	❑	❑
Do you have any disease, condition, or problems not listed above that you think I should know about?	❑	❑

_____

_____

ADULT MEDICAL HISTORY (13 YEARS AND ABOVE)

	YES	NO
7. Are you taking or have you taken, any diet drugs such as Pondimin® (fenfluramine), Redux® (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑
8. Are you taking, or scheduled to begin taking any of the medications alendronate (Fosomax®), risedronate (Actonel®) or ibandronate (Boniva®), for osteoporosis or Paget's disease?	❑	❑
9. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia®, Bonefos® or Zometa®) for bone pain, hypercalcemia or skeleta complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	❑	❑

Date treatment began: _____

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

_____

_____

_____

10. Are you ALLERGIC to or have you had a reaction to:		
Local anesthetics	❑	❑
Aspirin	❑	❑
Penicillin or other antibiotic	❑	❑
Barbiturates, sedatives or sleeping pills	❑	❑
Sulfa drugs	❑	❑
Iodine	❑	❑
Other	❑	❑

If yes, explain: _____

_____

11. Have you ever had any allergic reaction to any latex products (balloons, surgical gloves, surgical tubing, etc.)	❑	❑
12. Do you smoke? If yes: ❑Daily ❑Socially	❑	❑
13. Do you use smokeless tobacco?	❑	❑
14. Do you drink alcoholic beverages? If yes: ❑Daily ❑Socially	❑	❑
15. Do you use drugs or other substances for recreational purposes?	❑	❑

If yes, please list:

_____

	YES	NO
16. Are you alcohol and/or drug dependent?	❑	❑
If yes, have you received treatment?	❑	❑
17. Have you had any unexplained or unplanned weight loss recently?	❑	❑
18. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, when was this operation done?	❑	❑

_____

19. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

WOMEN ONLY

20. Are you currently pregnant? Expected delivery date: _____	❑	❑
21. Nursing?	❑	❑
22. Taking birth control pills or hormonal replacement?	❑	❑

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____

Signature of Parent/Legal Guardian Date

_____

Doctor's Initials

PATIENT REGISTRATION

Welcome to our office. It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete these confidential questions so that we may better serve you.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

E-mail: _____ ☐ **I would like to receive correspondence via email.**

Birth Date: _____ Social Security #: _____ Drivers Lic.: _____

Sex: ☐Male ☐Female Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed

Employment Status: ☐ Full Time ☐Part Time ☐Retired

Student Status: ☐ Full Time ☐Part Time Name of School: _____

Employed by: _____

Employer Address: _____

Occupation: _____

Referred by: _____

RESPONSIBLE PARTY

Please complete the section below if someone other than the patient is responsible for the payment of services.

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to the Patient: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

E-mail: _____ ☐ **I would like to receive correspondence via email.**

Birth Date: _____ Social Security #: _____ Drivers Lic.: _____

Sex: ☐Male ☐Female Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed

Employment Status: ☐ Full Time ☐Part Time ☐Retired

Employed by: _____

Employer Address: _____

Occupation: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship of Patient to Insured: ☐ Self ☐Spouse ☐Child

Insured Social Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Group Number: _____ Policy Number: _____

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of ***September 1, 2015*** *there will be a fee of* ***$25.00*** *assessed (per half hour scheduled) if we do not receive sufficient notice to cancel an appointment.*

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Davenport Dental Group

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Date *Patient's Signature*

Davenport Dental Group

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.

Print Name: _____

Signature:_____ Date:_____

I authorize the release of PHI (Private Health Information) to the listed family members:

Name and Relation:_____

_____

_____

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

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

_____

_____

DAVENPORT
DENTAL GROUP

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/15/2003 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new notice clearly and prominently at our practice location, and we will provide copies of the New Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment for you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use and disclose your health information when we are required to do so by law.

Public Health Activities. We may use and disclose your health information for public health activities, including disclosure to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition, or;
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspection, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on your use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) Whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purpose of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our website or by electronic mail (email).

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 if 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.

Our Privacy Official: **Kimberly A. Martin**

Telephone: **(956) 726-9980** Fax: **(956) 717-3359**

Address: **1310 Junction Dr., Suite D Laredo, TX 78041**

Email: **kimberlym@davenportdentalgroup.com**