OC Advanced Periodontics
Oral Wellness & Implant Dentistry

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative (name):

Newspaper Ad Radio Ad TV Ad Ad in Mail Saw our Office

Insurance Company Our Website Search Engine (Google, etc.) Other Website:

Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

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Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency_Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

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Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize OC Advanced Periodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to OC Advanced Periodontics. I permit a copy of this authorization to be used in place of the original. I give OC Advanced Periodontics, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -

Address:	City:	State:	ZIP Code:

What did you like about your last dentist?	What caused you to leave your last dentist?

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? Yes No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?

Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:	Are you interested in regular hygiene cleanings?

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?

Tooth Pain Check-up Cleaning Whitening Cosmetic Dentistry
Sedation Dentistry Restorative Dentistry Other:

Dental Concerns

Cicle all that apply.

Teeth

Broken or chipped	Loose/missing filling	Missing teeth	Sensitive to sweets
Crooked	Loose teeth	Mouth sores	Blisters on lips/mouth
Decay	Tooth pain	Sensitive to cold	Orthodontic treatment
Difficulty chewing	Food trap areas	Sensitive to heat	Bad taste in mouth
Discolored	Grinding or clenching	Sensitive when biting	

Gums

Bad breath	Abscessed	Sore	Receding
Red (discolored)	Bleeding	Swollen	Periodontal treatment

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Facial/Jaw Pain

Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	

Other Concerns

Smoking/dipping	Orthodontic treatment	Snoring
Biting cheeks or lip	Burning tongue	Teeth straightening
Popping/clicking	Tooth replacement	Retainer
TMJ	Fractured tooth syndrome	Dry mouth
Tooth-colored fillings	CPAP	Wisdom teeth extraction
Wisdom teeth	Implants - Tooth #:	Cosmetics
Nail-biting	Jaw locks open/closed	Smile makeover
Sleep apnea	Stain	Dental phobias
Limited orthodontics	Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Have you ever had:

Cicle all that apply.

Orthodontic treatment	Periodontal treatment	Your bite adjusted
Oral surgery	Your teeth ground	A bite plate or mouth guard

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

Ratings

1 2 3 4 5	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.
1 2 3 4 5	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?
1 2 3 4 5	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?
1 2 3 4 5	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
1 2 3 4 5	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?

1 2 3 4 5	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?

Miscellaneous

Has fear ever been an issue for you in a dental office? Yes No

Has time ever been a factor in getting your dental work done? Yes No

Has the cost of dental treatment been a concern for you? Yes No
If yes, how can we help?

Tell us about your good dental experiences/visits:	Tell us about your bad dental experiences/fears:

What do you like most about your teeth/smile?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

What are your long-term dental goals? How would you like your teeth to feel and look?

What are your short-term dental goals?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Is there anything else you feel we should know?

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

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Do you require antibiotic pre-medication for your dental work? If yes, what for?				
Physician's Name:	Phone: - -	Last Visit: /		
Address:	City:	State:	ZIP Code:	
Do we have permission to contact your doctor regarding your care? Yes No				

Have you ever had:

Check all that apply.

Arthritis	Seizures	Abnormal bleeding	Recent weight loss
Arteriosclerosis	Fainting	Ulcers/colitis	Rheumatism
Birth defects	Hearing disorders	Difficulty breathing	Scarlet fever
Cancer	High or low blood sugar	Hospitalized for any reason	Sexually transmitted disease
Emotional problems			
Head or face injury	Hypotension (low blood pressure)	Emphysema	Sickle cell anemia
Heart murmur/trouble		Glaucoma	Sinus trouble
History of substance abuse/drug addiction	Nervous disorder	Thyroid disease	Tattoos/body piercing
Kidney problems	Heart attack/stroke	Artificial hip/joints	X-ray or cobalt treatment
Numbness of arms or hands	Heart surgery	Gout	Pacemaker
Chest pain	Yellow jaundice		
Swollen, still painful joints	Artificial valves	Circulatory problems	Chronic fatigue syndrome
Allergies	Congenital heart defect	Cold sores	Cough-persistent or bloody
Asthma	Mitral valve prolapse	Congenital heart lesion	Latex sensitivity
Blood disease	Artificial bones/joints	Cortisone medicine	Smoker
Diabetes	Shingles	Convulsions	Swelling of feet/ankles
Endocrine problems	HIV/AIDS	Herpes	Swollen neck glands
Intestinal disorders	Blood transfusions	Leukemia	Tonsillitis
Hepatitis A, B, or C	Fever blisters	Excessive thirst	
Hypertension (high blood pressure)	Sinus problems	Hay fever	Tumor or growth on head/neck
Heart disease	Severe/frequent headaches		
Liver problems	Hives/skin rash	Easily winded	
Pneumonia	Cancer/chemotherapy	Hypoglycemia	Anaphylaxis
Shortness of breath	Radiation treatments	Irregular heartbeat	Alzheimer's disease
Anemia	Psychiatric problems	Lung disease	Frequent diarrhea
Bruise easily	Tuberculosis	Osteoporosis	Genital herpes
Dizziness	Venereal disease	Pain in jaw joints	Renal dialysis
Epilepsy	Hemophilia	Parathyroid disease	Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

Acrylic	Dental anesthetics	Nitrous oxide	Tetracycline
Aspirin	Erythromycin	Novocaine	Valium
Barbiturates (sleeping pills)	Iodine	Penicillin/antibiotics	Xylocaine
Codeine	Metals	Sulfa drugs	Latex rubber Sedatives

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No

Do you take or have you taken Phen-Fen or Redux? Yes No

Do you smoke or chew tobacco? Yes No

Do you use alcohol, cocaine, or other drugs? Yes No

Do you wear contact lenses? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use more than two pillows to sleep? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

Have you been treated in a hospital in the last five years? Yes No

If female, please mark if you are:

Pregnant - If so, please enter your due date or week #:

Trying to get pregnant Nursing On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? Yes No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:

Reviewed by: Title: Date: / /

HIPAA 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 the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your 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.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- 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 be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical
- devices Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations Uses
- or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- 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 provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 30, 2016, and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

OC Advanced Periodontics
Oral Wellness & Implant Dentistry

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize OC Advanced Periodontics to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

If signing on behalf of someone, explain your relationship to the patient:

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:

Describe your good faith effort to obtain the individual's signature on this form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /