Welcome!

*WHOM MAY WE THANK FOR REFERRING YOU?*____________________

PATIENT INFORMATION

PATIENT NAME____________________ BIRTHDATE____________________

ADDRESS____________________

CITY____________________ STATE____________________ ZIP____________________

PHONE NUMBERS

WORK #____________________ CELL #____________________

HOME #____________________ E-MAIL____________________

FOR EMERGENCY, NOTIFY____________________ PHONE #____________________

ADDITIONAL INFORMATION

OCCUPATION____________________ EMPLOYER____________________

S.S. #____________________ DRIVER'S LIC.____________________

SPOUSE/SIGNIFICANT OTHER____________________

EMPLOYER____________________ PHONE #____________________

S.S. #____________________ BIRTHDATE____________________

INSURANCE INFORMATION

INSURANCE NAME:____________________ GROUP #____________________

GROUP NAME:____________________ POLICY HOLDER ID #____________________

PHONE #____________________

GELLER

Medical History

Name: ______________________________

When was your last physical examination? ______________

Are you currently receiving any medical treatment?........Yes/No

Reason: ______________________________

Have you been hospitalized or had serious illness within the last 5 years?........Yes/No

Have you ever had any of the following?

- Cardiovascular Disease Yes/No
  - Infective Endocarditis
  - Hypertension
  - Ischemic Heart Disease
  - Cardiac Arrhythmia
  - Heart Failure
  - Congenital Heart Disease
  - Heart Murmur/Mitral Valve Prolapse
- Pulmonary Disease Yes/No
  - Asthma
  - COPD
  - Tuberculosis
  - Sleep-Related Breathing Disorder
- Gastrointestinal Disease Yes/No
- Neurological Disorder Yes/No
  - Epilepsy
  - Stroke
  - Parkinson
- Adrenal Insufficiency Yes/No
- Thyroid Disease Yes/No
  - Hyperthyroidism
  - Hypothyroidism
- Diabetes Mellitus Yes/No
  - Type 1
  - Type 2
- Immunologic Disease Yes/No
  - AIDS/HIV
  - Rheumatoid Arthritis
  - Organ and Bone Marrow Transplant
  - Allergy
- Bleeding Disorder Yes/No
- Hepatitis Yes/No
- Psychiatric Disorder Yes/No
- Cancer Yes/No
- Drug Dependence Yes/No
- Chronic Renal Failure and Dialysis Yes/No
- Sexually Transmitted Diseases Yes/No

Have you had any prosthetic surgery? (i.e. Knee Replacement, Hip Replacement, Prosthetic Heart Valve)........Yes/No

Do you smoke?........Yes/No

If so, how much? __________

Do you drink alcoholic beverages?........Yes/No

Do you or have you in the past used recreational drugs regularly?........Yes/No

Women,

Are you pregnant?........Yes/No

If yes, how far along are you? ______________

Are you breastfeeding?........Yes/No

Have you experienced any allergies from any of the following?

- Local Anesthetic
- Penicillin or other antibiotics
- Barbiturates
- Sulfa drugs
- Aspirin
- Latex
- Other: ______________

Are you taking any of the following?

- Antibiotics
- Anticoagulant (blood thinners)
- Medicine for high blood pressure
- Cortisone
- Tranquilizers
- Aspirin
- Insulin, Tolbutamine (Orinase), or similar drug
- Digitalis
- Nitroglycerin
- Fen-Phen
- Biphosphonates
- Oral Contraceptive

Signed: Patient/Parent/Guardian ______________________________. Date ________

Doctor Signature: ______________________________. Date________

GELLER

Name: ______________________________ Date: ____________

Dental Questionnaire and History

Please check yes or no to indicate if you have any of the following

Bad Breath	Yes No	Grinding teeth	Yes No
Bleeding gums	Yes No	Lip or cheek biting	Yes No
Gums swollen or tender	Yes No	Mouth breathing	Yes No
Blisters or sores on lips and/or mouth	Yes No	Pain or bleeding when brushing	Yes No
Burning Sensation on tongue	Yes No	Orthodontic treatment	Yes No
Clicking or popping jaw	Yes No	Periodontal Treatment	Yes No
Jaw pain or tenderness	Yes No	Sensitivity to cold or heat	Yes No
Dry mouth	Yes No	Sensitivity to sweets	Yes No
Food collection between the teeth	Yes No	Sensitivity when biting	Yes No

How often do you brush? ____________ How often do you floss? ____________

Briefly tells us how you feel about your teeth, your smile, and dental expectations

When was your last dental appointment? ____________

What was the purpose of the visit? ____________

What are your primary goals for visiting the dentist? ____________

____

If you are already missing some teeth, do you want them replaced? Yes No

Rate your smile on a scale of 1-5, with 1 being the lowest score and 5 being the best possible ____________

If you are unhappy with your smile, what changes would you like to see? ____________

____

Are you interested in whitening? Yes No

Do you ever feel anxious or nervous about dental treatment? (circle) Never Sometimes Always

Have you ever had nitrous oxide (laughing gas), general anesthesia, IV or oral sedation during a dental appointment? Yes No

Has your past dental office experiences been positive? Yes No

If no, please explain: ____________

____

Is there anything in particular you would always like us to do for you? (neck pillow, blanket, etc.) Yes No

Explain: ____________

Do you have any dental concerns not listed here that you would like to bring to our attention? Yes No

Explain: ____________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.