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. This notice takes effect August 2019 and will remain in effect until we replace it. It describes how health information about you may be used and disclosed by our practice and how you can obtain 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. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. We must follow the privacy practices that are described in this Notice while it is in effect. 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 laws, 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, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. 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 to you, or to a care provider that is overseeing other health needs you may have. **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, or we could require a 3rd party to aid in collection of unpaid balances that are due. **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 will disclose your health information when we are required to do so by law. **Public Health Activities.** We may disclose your health information for public health activities as required by law, including disclosures 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 authorize 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 personal health information 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 personal health information 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 personal health information to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for

the 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 personal health information 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 personal health information 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. It should however be noted that we typically do not participate in research projects and this release is unlikely. **Privacy Notice Coroners, Medical Examiners, and Funeral Directors.** We may release your personal health information 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 personal health information to funeral directors consistent with applicable law to enable them to carry out their duties. **Fundraising**. By law, 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 fundraising communications. Our office policy is to NOT fundraise with patient information. **Other Uses and Disclosures of Personal Health Information**. If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work hard to secure all patient health information to protect individual privacy. **YOUR HEALTH CARE 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 still have the right to receive a printed, or if possible, 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 any 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 our use or disclosure of your person health information 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 purposes 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 on file. **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 decided 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 Web site or by electronic mail (e-mail). **For more information about our Privacy Practices, please contact Smile 24 Dentistry, LLC or U.S. Department of Health Services Office of Civil Rights.**

Revised
7/12/19

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement *

I, _____, have received a copy of the Smile 24 Dentistry, LLC Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Smile 24 Dentistry, LLC Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____
_____

Smile 24 Dentistry, LLC

Patient Personal Confidential Information

Patient Name: _____ **Date**: _____
Last First MI

Prefer to be called: _____

Address:_____
Street City State Zip Code

Birth Date: _____ **Gender** (circle): *M / F* **Family Status** (circle)*: Single / Married / Other*:

*If Child, please provide Parent/Guardian name:_____

Social Security # _____ **Driver's License**: _____

Phone (Home): _____ **(Work):** _____**Ext**:_____

Cell Phone: _____ **Email address** _____

How did you hear about us? _____ Referred by:_____

Emergency contact person:_____ **Relationship**: _____**Tel. No**.: _____

Employment Information

Employer Name: _____ **Occupation**: _____

Address: _____
Street City State Zip Code

ACCOUNT INFORMATION

Primary Dental Insurance Information

Insurance Company Name:_____

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

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured (*circle*): Self / Spouse / Child / Other _____

Insurance Plan Name and Address: _____

Tel. Number ( ) _____

Please see Back

Secondary Dental Insurance Information

Insurance Company Name:_____

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

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____
Street *City* *State* *Zip Code*

Patient's relationship to insured (*circle*): Self / Spouse / Child / Other _____

Insurance Plan Name and Address: _____

Tel. Number ( ) _____

Person Financially Responsible

Name:_____ Relationship to Patient: _____

SSN:_____

Address:_____ City:_____ State:____ Zip code:_____

Tel. Number ( )_____ Cell Number: _____ Email:_____

Person Responsible for Treatment Decisions If Different

Name:_____ Relationship to Patient: _____

SSN:_____

Address:_____ City:_____ State:____ Zip code:_____

Tel. Number ( )_____ Cell Number: _____ Email:_____

NOTE: Smile 24 Dentistry, LLC will assist you to maximize your dental insurance benefits by helping you file claims to your insurance carrier. It is important to understand that regardless of what your insurance plan pays, you are responsible for all fees.

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the Dental Office to submit claims and for the insurance companies to remit payment(s) to the Dental Office.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles **my insurance company does not cover within 60 days of service.**

_____ _____
Signature of Patient, Parent or Guardian Date

Patient Name: _____
Last *First* *MI*

PATIENT INFORMED CONSENT

DOB: _____/_____/_____
Mo *Day* *Year*

GENERAL INFORMATION: Smile 24 Dentistry, LLC is a private dental care office and patients accepted into the office will have their treatment performed by Dr. Vitanov and/or members of the team. The treatment will meet or exceed the Standards of Care and will be provided in a considerate, respectful, and confidential manner. Smile 24 Dentistry, LLC maintains all current clinic compliance policies required to maintain a healthy and safe environment for our patients.

CONSENT TO DENTAL PROCEDURES: As a patient you will have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, which may include treatment provided by Dr. Vitanov or other doctors, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. Before receiving treatment you should ask the dentist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-RAYS: Dental radiographic images will be made as necessary and appropriate for examinations, diagnosis, consultation, and treatment. Additional radiographic images such as Panoramic x-ray and/or Cone Beam Computed Tomography may be required and patient would be referred to an imaging center to obtain the x-ray on their own expenses.

FINANCIAL RESPONSIBILITY: You will be charged for treatment according to the fee schedule in effect. Fees may vary depending on the dental care provider, other dentists or dental specialist (if required). A fee estimate will be provided prior to beginning treatment and you must be prepared to pay for services as they are performed. Fees are collected in full at the completion of a procedure unless other arrangements are made in writing. If for some reason you do not pay in full for the treatment provided that day, any balance remaining on your account ninety days after treatment will result in your account being turned over to a collection agency. You will be responsible for any collection or legal fees which may be incurred as a result of your failure to pay for your dental work.

DENTAL INSURANCE: Smile 24 Dentistry, LLC in some cases does not accept direct assignment of insurance benefits. Our office will assist you with your dental insurance by completing the claim forms and returning them to you so that you can be reimbursed by the insurance carrier. Please check with our insurance coordinator or other front desk personnel to determine which insurance plans can be accepted for direct reimbursement to our office.

DENTAL MEDICAL RECORDS: The dental medical records, radiographic images, photographs, videos, models and other diagnostic aids relating to your treatment are the property of Smile 24 Dentistry, LLC. You have the right to inspect such materials and to request a copy of your dental medical records and radiographic images. A fee of $50.00 may be required for copying these items. In addition, a fee of $200.00 would be charged if patient decides to obtain the study/diagnostic cast models that were fabricated by the office. You may also request to have your dental radiographic images sent to another health care provider by signing a Release of Information form. Smile 24 Dentistry, LLC also complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and you will receive separate information, forms and consents in that regard. **In addition, your dental medical record may be used for instructional purposes and if it is, your identity will not be disclosed to individuals not involved in your care and treatment.**

KEEPING YOUR APPOINTMENTS: It is important for you to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify our office at least 24 hours in advance. A total of two cancellations without 24 hour notice, more than two missed appointments, or repeated unsuccessful attempts to arrange an appointment may result in the discontinuance of further treatment at Smile 24 Dentistry, LLC.

DISCONTINUANCE OF TREATMENT: Our office reserves the right to discontinue dental treatment whenever it is considered advisable and in the best interest of you and our office. Should treatment be terminated, any remaining credit balance for services not yet provided will be refunded to you.

I do hereby acknowledge, agree and give my voluntary consent for treatment provided through the Smile 24 Dentistry, LLC as may be deemed necessary or desirable by my treating professional(s), their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, and x-rays. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at the Smile 24 Dentistry, LLC. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care. **Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.**

Date: _____ Signature: _____

If signed by other than the patient, Indicate relationship: parent or legal guardian: _____

Witness Signature: _____

General Consent

(Common risks associated with any dental procedure)

Thank you for choosing Smile 24 Dentistry, LLC for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or Chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
2. Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Swallowing or inhaling small objects.

While we follow procedural guidelines and standard of care which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

By writing my name below, I indicate I have read and understand the statement on this page:

Patient Name or (Legal Guardian):_____ Date:_____

General Consent

(Dental Procedures)

DRUGS AND MEDICATION: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

REMOVAL OF TEETH: I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, so of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

CROWNS, BRIDGES AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also any responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Please check yes if you understand, and please write you initials in the box below: Yes
Initials:

ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

FILLINGS: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay; I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

Please check yes if you understand, and please write your initials in the box below: Yes
Initials:

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Please write your name to indicate your agreement with this policy:_____
Date:_____

Smile 24 Dentistry, LLC

Financial or Insurance Policy

Thank you for choosing Smile 24 Dentistry, LLC for your dental needs. We are committed to your successful treatment. The following is a statement of our Financial and Insurance Policy. We consider it to be a very important part of your treatment. We require you to read and sign this document prior to any dental treatment completed.

Payment Arrangements:

Payment in full at the time of service is expected, unless a written agreement is in place and signed prior to rendered treatment. Nonpayment, payment reversal, returned items or other default of these terms will result in bank, and/or collection fees assessed to your account. Any unpaid amounts remaining on your account after 30 days will result in a service charge of 1.5% per month.

Cancellation Policy:

We ask for at least 2 business days advance notice for canceling or rescheduling an appointment; otherwise, a fee of $60 may be assessed to your account.

Regarding Insurance:

We will be happy to assist you in determining your dental insurance benefits based on the information you provide us. If your dentist is a participating provider with your insurance plan, you will be billed according to the contracted fees with your insurer.

Dental insurances commonly negotiate discounts for services provided to their members. Should you exceed your annual benefit maximum, the discounted rates may continue to be applied to subsequent services.

If your dentist is not a participating provider with your insurance plan, we will honor the out of network benefit and fee structure of your insurance company. Should your insurance plan not accept assignment of benefits to your dentist, you are responsible for the estimated insurance portion

Third-Party Financing:

Smile 24 Dentistry LLC accepts payment from non-affiliated, third party financing companies. Credit decisions are the responsibility of the third-party financing company, and not Smile 24 Dentistry LLC. You may choose to pay for some or all of your treatment costs using an approved third-party company.

I have read the Financial and Insurance Policy. I understand and agree to the terms.

Patient/Responsible Party: _____ Date:_____

MEDICAL – DENTAL HEALTH QUESTIONNAIRE

TO BE COMPLETED BY THE PATIENT OR LEGAL GUARDIAN (if patient is <18 yrs):

Gender: M / F Race: _____ Are you currently under a physician's care? YES / NO

Date of last physician visit:_____ Reason:_____

Physician #1 Name:_____ Physician #1 Phone #_____

Physician #1 Address:_____

Physician #2 Name:_____ Physician #2 Phone #_____

Physician #2 Address:_____

GENERAL HEALTH QUESTIONS (please circle: Y, N, or ?)

Y N ?

Have you previously been a patient of record at Smile 24 Dentistry, LLC? Date:_____

Have there been any changes in your general health in the last year?

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

Reason:_____

Have you traveled into/outside of the United States in the past 30 days?

Explain:_____

Do you have chronic pain? Where? _____

Night sweats?

Unintended weight loss or gain?

Has your physician recommended that you take antibiotics prior to dental treatment?

Have you had an orthopedic total joint replacement? When?_____

Do you have a heart murmur or a history of rheumatic heart disease?

Have you taken Pondimin (fenfluramine), Redux (dexphenfluramine) or Fen-Phen (phentermine)? If "Yes", how long?_____

Have you taken Fosamax (Alendronate), Actonel (Risedronate), or Boniva (Ibandronate)? If "Yes", how long?_____ I.V. or Oral ?

Have you taken cortisone (steroids) in the last 30 days?

SOCIAL HISTORY QUESTIONS

Y N ?

Do you drink any type of alcohol daily? Type/Amount:_____# Years_____

Do you use recreational (street) drugs?_____

Have you been treated for chemical or alcohol dependency?_____

Do you use Tobacco? Type:_____Amount/Years:_____

Y	N	?	Allergies
☐	☐	☐	Local anesthetic (e.g. Novocaine)
☐	☐	☐	Penicillin / antibiotics
☐	☐	☐	Barbiturates
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Latex
☐	☐	☐	Nickel (jewelry, clothing snaps)
☐	☐	☐	Acrylic
☐	☐	☐	Food

Type of reaction: _____

Other allergies: _____

Physical Exam / Laboratory studies

Height: _____

Weight: _____

Glucose: _____

Other: _____

_____

_____

Y	N	?	Females only
☐	☐	☐	Post-menopausal or post hysterectomy
☐	☐	☐	Are you pregnant? Due date: _____
☐	☐	☐	Are you currently breast feeding?
☐	☐	☐	Are you currently taking birth control medications? What type? _____

Current Medications

(Including prescribed, over-the-counter, and herbal or natural)

Medication	Dose/day	Date started	Drug action	Prescribed for

DENTAL HISTORY

Chief concern/expectations: _____

_____

Last time you received routine dental care? _____

Dentist name: _____

Last dental x-rays? _____

Reason for last dental visit? _____

Will any of the following make it difficult to complete dental care?

- ☐ Fear or anxiety
- ☐ Lack of time
- ☐ Lack of funds/cost
- ☐ No insurance
- ☐ No transportation
- ☐ Other: _____

What problems/complications with dental care have you had in the past? _____

_____

HYGIENE PRACTICES

Do you drink fluoridated water? _____

Toothpaste? _____

Toothbrush? _____

Floss? _____

Mouth rinse? _____

Other self care? _____

Oral hygiene: ☐ Adequate ☐ Inadequate

Motivation level: ☐ High ☐ Medium ☐ Low

Indicate any past major dental treatment

- ☐ Orthodontics (braces)
- ☐ Oral surgery (tooth extraction)
- ☐ Periodontics (gum treatment or surgery)
- ☐ Endodontics (root canal)
- ☐ Partial dentures
- ☐ Full dentures
- ☐ Crown and bridge work
- ☐ TMJ treatment

What would you change about the appearance of your teeth? _____

Y	N	Are your teeth sensitive to:
☐	☐	Sweets
☐	☐	Hot
☐	☐	Cold
☐	☐	Pressure (chewing)

Y	N	Salivary function:
☐	☐	Does your saliva feel thick or ropey?
☐	☐	Does you mouth feel dry?
☐	☐	Do you have difficulty chewing food?
☐	☐	Do you have difficulty swallowing?
☐	☐	Do you have difficulty speaking?
☐	☐	Do you have excessive saliva?

Y	N	Please check all that apply:
☐	☐	Do you have any swelling in your mouth?
☐	☐	Are your teeth shifting?
☐	☐	Are any of your teeth loose?
☐	☐	Do you have any food impaction between teeth?
☐	☐	Are you aware of any loose, broken, or missing fillings or chipped teeth?

Dentures

How long worn? _____

Age of present dentures _____

How many past dentures? _____

Any current problems? _____

SYSTEMS REVIEW — CHECK ALL THAT APPLY

CARDIOVASCULAR CONDITIONS:

- ☐ ☐ Angina
- ☐ ☐ Atherosclerosis
- ☐ ☐ Artificial heart valve date: _____
- ☐ ☐ Pacemaker/defibrillator date: _____
- ☐ ☐ Irregular heartbeat/arrhythmia
- ☐ ☐ Heart attack date: _____
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Congenital heart defect
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Bypass surgery date: _____
- ☐ ☐ Tire easily
- ☐ ☐ Chest pain, shortness of breath, swelling in ankles

RESPIRATORY CONDITIONS:

- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Chronic bronchitis
- ☐ ☐ Asthma
- ☐ ☐ Seasonal allergies
- ☐ ☐ Sinusitis
- ☐ ☐ Tonsil or adenoid conditions

GASTROINTESTINAL CONDITIONS:

- ☐ ☐ Colon disorders
- ☐ ☐ Persistent diarrhea
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Gastroesophageal reflux
- ☐ ☐ Ulcers
- ☐ ☐ Malnutrition
- ☐ ☐ Jaundice
- ☐ ☐ Gallbladder trouble/stones
- ☐ ☐ Liver disease
- ☐ ☐ Cirrhosis
- ☐ ☐ Other liver conditions
- ☐ ☐ Pancreas

ENDOCRINE CONDTIONS:

- ☐ ☐ Thyroid problems: _____
- ☐ ☐ Parathyroid problems: _____
- ☐ ☐ Diabetes Type: _____ Date of diagnosis: _____
- ☐ ☐ Hypoglycemia

GENETOURINARY CONDITIONS:

- ☐ ☐ Kidney problems
- ☐ ☐ Dialysis
- ☐ ☐ Bladder infection

VIRAL/BACTERIAL INFECTIONS:

- ☐ ☐ AIDS or HIV infection
- ☐ ☐ Herpes simplex (chicken pox/shingles)
- ☐ ☐ HPV
- ☐ ☐ Hepatitis A B C
- ☐ ☐ Gonorrhea
- ☐ ☐ Cytomegalovirus (CMV)
- ☐ ☐ Epstein-Barr virus (EBV)
- ☐ ☐ Chlamydia
- ☐ ☐ Mononucleosis
- ☐ ☐ Other: _____

BONE AND JOINT CONDITIONS:

- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ Trauma/frequent fractures
- ☐ ☐ TMJ problems
- ☐ ☐ Jaw surgery

BLEEDING ABNORMALITIES:

- ☐ ☐ Prolonged bleeding
- ☐ ☐ Bruise easily
- ☐ ☐ Anemia
- ☐ ☐ Platelet disorder
- ☐ ☐ Sickle cell ☐ disease ☐ trait
- ☐ ☐ Hemophilia type: _____
- ☐ ☐ Blood transfusion year: _____

SYSTEMS REVIEW — CHECK ALL THAT APPLY

Y	N	NEUROLOGIC CONDITIONS:
☐	☐	Epilepsy
☐	☐	Convulsions/seizures
☐	☐	Stroke
☐	☐	Neuritis
☐	☐	Neuralgia/Tics
☐	☐	Chronic pain
☐	☐	Numbness/Paralysis
☐	☐	Severe frequent headaches
☐	☐	Migraines
☐	☐	Repeated blackouts/fainting
☐	☐	Glaucoma

Y	N	DERMATOLOGIC CONDITIONS:
☐	☐	Chronic/recurrent skin rash
☐	☐	Hives
☐	☐	Psoriasis
☐	☐	Eczema
☐	☐	Other: _____

Y	N	CANCER:
☐	☐	Site: _____
☐	☐	Surgery date: _____
☐	☐	Chemotherapy date: _____
☐	☐	Radiation therapy site: _____

Y	N	BEHAVIORAL HEALTH CONDITIONS:
☐	☐	Depression
☐	☐	Anxiety or panic disorders
☐	☐	Eating disorders
☐	☐	Bipolar
☐	☐	Schizophrenia
☐	☐	Post-traumatic stress disorder
☐	☐	Obsessive compulsive disorder
☐	☐	Other

Y	N	AUTOIMMUNE CONDITIONS:
☐	☐	Rheumatoid arthritis
☐	☐	Lupus
☐	☐	Multiple sclerosis
☐	☐	Myasthenia gravis
☐	☐	Fibromyalgia
☐	☐	Immunosuppressive drugs: _____
☐	☐	Immunosuppressive disease: _____
☐	☐	Organ or tissue transplant date: _____

Are you experiencing any difficulty due to unmet needs in any of the following areas of your life?	Y	N
Employment/Income limitations	☐	☐
Mental or behavioral health	☐	☐
Physical health / No insurance	☐	☐
Family (death, divorce, domestic violence, etc.)	☐	☐
Transportation	☐	☐
If you answered yes to any of the previous, would you be willing to meet with a patient advocate?	☐	☐

ADDITIONAL INFORMATION ON POSITIVE MEDICAL HISTORY RESPONSES (list by number)

MEDICAL PROBLEM LIST (to be completed by doctor)

DENTAL PROBLEM LIST (to be completed by doctor)

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Patient/Legal Guardian Signature:_____ Date: _____

Doctor Signature: _____ Date:_____

Witness Signature:_____ Date:_____