PATIENT HEALTH RECORD

Date _____

Dr. Mr. Mrs. Ms. _____ Spouses Name _____
(Last) (first) (initial)

Address _____
(Street) (city) (state) (zip code)

Home Phone (___)_____ Business Phone (___)_____ E-Mail _____

Date of Birth _____ Sex M F Height _____Weight _____ Married _____ Single _____

Occupation _____ Social Security No. _____ - _____ - _____

Emergency Contact - Name _____ Phone Number (_____) _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

What is your general state of health? Excellent _____ Good _____ Fair _____ Poor _____

Name and address and phone number of physician _____

_____

Have you been under a physician's care during the last two years? _____

Have you been treated in a hospital in the past three years? _____

Have you had major surgery? _____

History with general or IV anesthesia? _____

If female: Are you pregnant or nursing? _____

Do you or have you had any of the following?

Blood Pressure (office to take) _____

	Past	Present	None		Past	Present	None		Past	Present	None
Epilepsy or Seizures	❑	❑	❑	Kidney Problems	❑	❑	❑	Cancer	❑	❑	❑
Fainting or Dizziness	❑	❑	❑	Bruise/Bleeds easily	❑	❑	❑	Chemotherapy	❑	❑	❑
Stroke	❑	❑	❑	Heart Problem	❑	❑	❑	Radiation Therapy	❑	❑	❑
Persistent Cough	❑	❑	❑	Chest Pain/Angina	❑	❑	❑	Thyroid Disease	❑	❑	❑
Emphysema/Bronchitis	❑	❑	❑	Osteoporosis/Penia	❑	❑	❑	AIDS/HIV+	❑	❑	❑
Tuberculosis/PPD+	❑	❑	❑	Rheumatic Fever	❑	❑	❑	Arthritis	❑	❑	❑
Asthma	❑	❑	❑	Heart Murmur	❑	❑	❑	Fibromyalgia	❑	❑	❑
Sinus Problems	❑	❑	❑	Mitral Valve Prolapse	❑	❑	❑	High Blood Pressure	❑	❑	❑
Anemia/Sickle Cell	❑	❑	❑	Congenital Heart Lesions	❑	❑	❑	Gastric Reflux	❑	❑	❑
Hepatitis A, B, C	❑	❑	❑	Heart Surgery	❑	❑	❑	Heart Burn	❑	❑	❑
Liver Disease	❑	❑	❑	Artificial Heart Valves	❑	❑	❑	Snoring	❑	❑	❑
Pneumonia	❑	❑	❑	Pacemaker	❑	❑	❑	Sleep Apnea	❑	❑	❑
Nervousness/Anxious	❑	❑	❑	Artificial Joints	❑	❑	❑	Daytime Sleepiness	❑	❑	❑
Irregular Heart Beat	❑	❑	❑	Latex Allergy	❑	❑	❑	Diabetes	❑	❑	❑

Do you have any condition, disease, or problem not previously listed? _____

_____

_____

Please list all the medications you are taking, including over the Counter Drugs and Herbs

Medications:	Dosage/Day	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Yes	No
Do You Take Daily:		
Multivitamin	Yes	No
Fish Oil (Omega 3)	Yes	No
Joint Support	Yes	No
Other:		
_____		
_____		
_____		

Are you allergic to: ❑ Penicillin, ❑ Codeine, ❑ Local Anesthetics, ❑Other _____

DENTAL HEALTH

When was your last dental visit? _____ How often did you see your dentist? _____
Are you having any dental problems that require immediate attention? _____
Do you have frequent headaches? _____ Ear aches? _____ How often? _____
Is there anything that will cause your muscles to be tired or sore or cause headaches? _____
Are your jaw joints painful or tender? _____ If yes please describe _____
Have you had trauma to your jaw? _____ Do your jaw joints pop or click or grate? _____
Do your jaws ever feel tired or ache? _____ Have you ever been told you have TMJ? _____
Do you clench or grind your teeth? _____
Does your bite feel comfortable? _____ Have you noticed any change in your bite? _____
Have you ever been told you have periodontal disease? _____ Have you ever had periodontal treatment? _____
Do your gums bleed while cleaning? _____ Do your gums ever feel tender or swollen? _____
How often do you brush your teeth? _____ Floss? _____ Water Jet? _____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____
Have you noticed any changes in your teeth? _____
Do you have loose teeth? _____ Worn teeth? _____ Broken or chipped teeth? _____ Food Traps? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you lose fillings or break fillings? _____ Do you usually have cavities? _____
Have you ever had orthodontic treatment? _____ When? _____
Do you have any missing teeth? _____ Have they been replaced? _____
Do you have a Fixed bridge? _____ Removable partial? _____ Full dentures Dental Implants? _____
Are you comfortable with the replacement? _____ Please describe _____
_____
How do you feel about the appearance of your smile? _____
What improvements would you like to make in your mouth? _____
_____
Please add anything you feel is important: _____
_____
_____
_____

Signature _____ Date _____

PERSONAL DENTAL NEEDS SURVEY

Name: _____

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care. (The most important would be #1.)

___ Preventive Dental Health care
___ Excellence and Quality of service
___ Other_____
___ Freedom from pain.
___ Cost and Affordability

Please rate, as above, what a dentist has to do to gain your confidence.

___Show me what he/she is doing or needs to do so I can clearly understand what is happening.
___Listen to my concerns and explain thoroughly the procedures to be performed.
___Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have about your dental visits. (10 being the greatest fear.)
1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply.)

___Music and earphones (Please list the type of music)_____
___Sedative medications
___Nitrous Oxide
___ Patient education materials

Are you concerned about the following? (Yes or No):

_____Existing discomfort?
_____Replacing old silver fillings?
_____Recurring or untreated gum disease?
_____Mouth odor?
_____Whitening your teeth?
_____Appearance of my smile?
_____Prevention of decay?
_____Other_____

PLEASE CIRCLE ONE:

When discussing my treatment plan, I prefer:

THE BIG PICTURE DETAIL BY DETAIL

When evaluating my smile, it's most important:

WHAT I SEE WHAT OTHERS SEE

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. It also confirms that you have received a copy of our Notice of Privacy Practices.

Signature _____ Date _____

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. Under the law, we must have your signature on a written, dated Consent form and/or Authorization form (not an Acknowledgement form) before we will use and disclose your protected health information for certain purposes as detailed in the rules below.

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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information, x-rays and photos, in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, educational courses, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00. for each page, $6.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Janet DuPont, 390 4th Street North, Suite 101, St. Petersburg, Fl. 33701.
Tel:727-282-1980 Fax: 727-823-5588. E-Mail: JDuPont@DuPontWilkersonDentistry.com