# *Patient Information*

Michael G. Paat, DMD

First name _____ Middle Initial ____ Last name _____

Address _____City _____ State _____ ZIP _____

Date of Birth _____ Social Security # _____

Home phone _____ Cell phone _____ Work phone _____

Primary Contact Number? Home Cell Work

E-mail (optional) _____

Employer _____ Occupation _____

How did you hear about our office? _____

Emergency Contact_____ Phone _____

## *Dental History*

Reason for today's visit _____

Are you currently in pain? _____ if yes, please describe_____

Do you have any dental problems now? _____ if yes, please explain _____

Level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

Date of last dental exam? _____ Date of last x-rays? _____

Procedure(s) done at last dental visit _____

Do you require antibiotics before dental treatment? _____

Do your gums ever bleed when you brush? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No

Do you wear any removable dental appliances? Yes No

Have you ever had?

| | | |
|---|---|---|
| Periodontal disease/gum treatment | Yes | No |
| Orthodontic treatment | Yes | No |
| Oral Surgery | Yes | No |
| Bite Plate or Mouth Guard | Yes | No |
| Discomfort in your jaw joint | Yes | No |

If yes to any of the above questions, please explain: _____
_____
Is there anything else about your past dental treatment(s) that you would like us to know?
_____
_____

## *Medical History*

Have you been hospitalized or under the care of a medical doctor in the past 5 years? Yes No
If yes, please explain _____
_____

Physician Name_____
Physician Phone Number_____

Are you currently taking any medication (prescribed or over-the-counter)? Yes No
If yes, please provide us with the information in the space below or you can provide us with your own list:_____
_____
_____
_____

Do you currently smoke? Yes No
Do you currently use chewing tobacco? Yes No

**Women Only**
Are you pregnant or think you might be pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control or hormonal replacements? Yes No

**Allergies**

| | | |
|---|---|---|
| Aspirin | Yes | No |
| Anesthetics (Novocaine) | Yes | No |
| Codeine | Yes | No |
| Hay Fever/Seasonal | Yes | No |
| Iodine | Yes | No |
| Jewelry/Metals | Yes | No |
| Latex | Yes | No |
| Penicillin or Other Antibiotics | Yes | No |
| Sedatives | Yes | No |
| Sulfa Drugs | Yes | No |

Any other Allergies? _____
_____

To yes responses, please specify type of reaction_____
_____
_____
_____

| | YES | NO |
|---|---|---|
| Abnormal Bleeding | | |
| AIDS or HIV | | |
| Anemia | | |
| Arthritis | | |
| Artificial Heart Valve | | |
| Asthma | | |
| Blood Transfusion | | |
| Cardiovascular Disease (High or low blood pressure) | | |
| Chest Pain upon exertion | | |
| Diabetes- Type 1 (insulin dependent) | | |
| Diabetes-Type II | | |
| Disease, Drug or radiation-induced immunosuppression | | |
| Dry Mouth | | |
| Eating Disorder | | |
| Emphysema | | |
| Epilepsy | | |
| Fainting Spells or seizures | | |
| Frequent Headaches | | |
| G.E. Reflux/perisistant heartburn | | |
| Gastrointestinal disease | | |
| Glaucoma | | |
| Heart Attack | | |
| Hemophilia | | |
| Hepatitis or liver disease | | |
| Joint Replacement | | |
| Kidney Problems | | |
| Lupus | | |
| Mental Health Disorders | | |
| Mitral Valve Prolapse | | |
| Neurological Disorders | | |
| Recurrent infections | | |
| Rheumatoid Arthritis | | |
| Sinus Trouble | | |
| Sleep Disorder | | |
| Sores or ulcers in mouth | | |
| Stroke | | |
| Thyroid Problems | | |
| Tuberculosis | | |
| Ulcers | | |

# *Dental Insurance*

**Primary Carrier**

Insurance Co. Name _____

Group no. (Plan or Policy no.) _____ Insured's ID no. _____

Insured's Name _____ Relation to Patient _____

Date of Birth _____ Insured's social security no. _____

Insured's employer name _____

Is Insured a patient in our office? Yes No

**Secondary Carrier**

Insurance Co. Name _____

Group no. (Plan or Policy no.) _____ Insured's ID no. _____

Insured's Name _____ Relation to Patient _____

Date of Birth _____ Insured's social security no. _____

Insured's employer name _____

Is Insured a patient in our office? Yes No

**Please give your insurance card (if you have one) to Debbie or Ashley so we can copy it and keep in with your records. Thank you! **

**Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above; I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.

_____ _____

Signature of Patient Date

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORATION ABOVE WITH THE PATIENT NAMED HEREIN

INITIALS_____ DATE_____

Michael G. Paat, DMD

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INORMATION 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 01/01/2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right the make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we create 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 the 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 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, 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 your 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 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 your 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 our 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 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 to lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official have 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).

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**PATIENT RIGHTS**

**Access**: You have the right to look at or to 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 $0 for each page. If you request and 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.

**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 the 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, you are entitled to receive this Notice in written form.

Michael G Paat, DMD, PC

# ACKNOWLEGEMENT 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.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

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FOR OFFICE USE ONLY

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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 acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____
_____
_____
_____

Michael G. Paat, D.M.D
OFFICE POLICIES

- All payments are due at the time of service. For bigger procedures, such as crowns, bridges, implants, dentures, etc. we ask for half of the payment up front to help with the cost of materials and lab fees. We accept cash, personal checks, Visa, MasterCard, Discover and CareCredit.
- This office provides dental services that are in the best interest of our patients, not the insurance company. Some recommended or necessary procedures may not be covered due to the ever-changing insurance world and this office is not responsible for those fees.
- This office staff will complete and submit insurance forms for any patient who has dental insurance. Insurance deductibles must be met and paid prior to future dental work. The office is **NOT** responsible for insurance benefits not paid by the insurance carrier. Patients are responsible for maximum $$ insurance limits. Completed dental procedures are the financial responsibility of the patient or responsible party. **If there are any problems or questions concerning insurance coverage or denial, it becomes the patient's responsibility to contact the insurance company to resolve any outstanding matters.**
- Fees are subject to change at the reasonable discretion of the office. All fees quoted in discussed treatment plans are valid for only ninety (90) days.
- Any personal check returned by the bank for insufficient funds will be assessed a $35 fee and will jeopardize the future acceptance of check payments.
- Dental emergencies are a daily part of our office. Please understand that if you are in need of an emergency appointment, the office will do it's best to fit you in that day. However, please understand that you may have to wait, as you will be seen between regularly scheduled patients. For those regularly scheduled patients, please be understanding to the office if we are running late as a result of an emergency.
- Patients are encouraged to contact Dr. Paat at any time if they have a dental emergency. In the event that Dr. Paat is not available, instructions will be left on the answering machine for your care.
- Patients who plan to miss their scheduled appointment **MUST notify the office at least 24 hours in advance**. **Unannounced cancellations with less than 24 hour notice will result in a $45 broken appointment fee. If your appointment is scheduled for more than an hour, the broken appointment fee will be adjusted appropriately**.
- As the time for your appointment is crucial to your appropriate care, any patient who is more than ten (10) minutes late for an appointment may be rescheduled to the next available opening.

I certify that I have read, understand and take responsibility for all of the above information. As the responsible party for this account, I understand that the office will abide by these policies and enforce them at all times.

X_____ Date_____