

DENTAL HISTORY

Reason for today's visit/main concern? Cleaning/Check up Emergency/Toothache Other: _____

Previous dentist Information: _____

Do your gums bleed easily? NO YES Explain: _____

Have you had gum (periodontal) treatment? NO YES Explain: _____

Have you ever had prolonged bleeding after any dental treatment? NO YES Explain: _____

Do you grind your teeth, clench your jaw, or feel have symptoms such as clicking, popping, pain or lock jaw? NO YES
Explain: _____

Are your teeth sensitive to hot or cold? NO YES

Are there any other conditions we should be aware of? NO YES
Explain: _____

MEDICAL HISTORY

Physicians name: _____

Physicians phone #: _____

Are you currently under a doctor's care? NO YES
Explain: _____

Have you been hospitalized or had a serious illness within the past five years? NO YES
Explain: _____

(Woman) Are you currently pregnant? NO YES
How many months? _____
OBGYN information: _____

Are you required by your doctor to pre-medicate for any condition? NO YES
Drug name and quantity: _____

Please list all medications you are currently taking and for what condition, if any:

PLEASE CHECK IF YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING

- | | |
|--|--|
| <input type="checkbox"/> ARTIFICIAL LIMBS/JOINTS | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIZZINESS/FAINTING |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> STOMACH PROBLEMS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> STD: _____ |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEPATITIS: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C |
| <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> JAUNDICE |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> CHEMO/RAD THERAPY | <input type="checkbox"/> LIVER PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> LUNG DISEASE |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> HEART ATTACK |

Are there any other health problems of which we should be advised?
Please specify: _____

Please mark any known allergies/adverse reactions:
 Penicillin Local Anesthetic Sulfa Drugs
 Ibuprofen Tetracycline Codeine
 LATEX Erythromycin
 Other: _____

EAST HAMPTON DENTAL GROUP POLICY

As a courtesy to me, the office staff will help prepare and file the insurance claims should I be insured. However, the agreement of the insurance company to pay is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. I understand that East Hampton Dental Group does not participate with any insurance company. I understand that East Hampton Dental Group expects full payment at the time services are rendered unless arrangements have been made prior to the start of any treatment.

I certify that I have read and accurately answered the above information to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize East Hampton Dental Group to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnoses of my dental condition. If I ever have any change in my health, I will inform the doctors at the appointment without fail.

Signature of patient/parent/guardian

Date

CHILD MINOR CONSENT

I, _____ being the parent/guardian of (child) _____ do hereby authorize East Hampton Dental Group to perform the necessary dental services for my child, including but not limited to, radiographs, anesthesia which are deemed advisable by the doctor. Whether or not I am physically present at the actual appointment when the treatment is rendered.

Signature of patient/parent/guardian

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 will remain in effect until we replace it.

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 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 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.

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.

**East Hampton Dental Group
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Ehdental@gmail.com**

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature of patient/parent/guardian

Date