Family Roots
DENTISTRY

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI

I prefer to be called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: _____ SS#: _____

Home Address: _____
Apt/Unit #

_____
City State Zip

Single Married Divorced Widowed Separated

Home: (____)_____ Cell: (____)_____

Employer: _____

Employer's Address: _____

Occupation: _____

Whom may we Thank for referring you?_____

Previous/Present Dentist: _____
(Please Circle)

Dentist Phone #: (____)_____ Last Visit Date: _____

In case of an emergency who should be notified?

_____ (____)_____
Name Phone #

2 Medical History

Are you currently under the care of a physician? Yes No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Please explain: _____

Your current physical health is: Good Fair Poor

Do you smoke, vape, or use tobacco/marijuana products in any form? Yes No

Do you have any metal rods, pins, or implants? Yes No

Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No

Please list each one:

_____

_____

_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin

Y N Codeine Y N Jewelry/Metals Y N Other

Y N Anesthetics Y N Latex

Please list any other drugs/materials that you are allergic to: _____

_____

_____

2 Medical History (cont.)

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding/Hemophilia	Y N	Herpes/Fever Blisters
Y N	Alcohol/Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	Hospitalization
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones/Joints/Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Therapy
Y N	Difficulty Breathing	Y N	Rheumatic Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease
Y N	Glaucoma	Y N	Stroke
Y N	Thyroid Problems	Y N	Heart Attack/Surgery
Y N	Tuberculosis (TB)	Y N	Heart Murmur
Y N	Ulcers	Y N	Hepatitis
Y N	Venereal Disease	Y N	Vitamin D Deficiency

Please list any additional medical condition(s) not listed above:

_____

_____

_____

For Women Only

Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that 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.

_____
Signature Date

MEDICAL HISTORY UPDATES (To be completed by patient annually)

I have reviewed my medical history, made changes as needed, and confirmed that it is current and accurate.

Initials: _____ Date: _____

I have reviewed my medical history, made changes as needed, and confirmed that it is current and accurate.

Initials: _____ Date: _____

I have reviewed my medical history, made changes as needed, and confirmed that it is current and accurate.

Initials: _____ Date: _____

5 Dental History

What is the goal of your dental visit today? _____

I am interested in: (Please circle all that apply)

Teeth Whitening	Cosmetic Evaluation	Straight Teeth	Replacing Missing Teeth
Sedation	White Fillings	Home Care	Breath Control

Are you currently in any dental pain? y N

Does dental treatment make you nervous? Y N If yes, check one: ____ Slightly ____ Moderately ____ Extremely

Have you ever had trouble getting numb or adverse reactions to local anesthetic? Y N

Have you ever had a toothache, cracked filling, or a chipped/cracked tooth? Y N

Did you ever have orthodontic treatment? Y N

Have you had any teeth removed? Y N

Do you have missing teeth that never developed? Y N

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? No Yes (Circle all that apply)

Color Shape Size Crowding Spacing Worn/Broken Teeth

Have you ever whitened (bleached) your teeth? Y N

Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) Y N

Do you have tension headaches or sore teeth? Y N

Do you wear or have you ever worn a bite appliance (such as a nightguard or mouthguard)? Y N

Bite/Chewing Function

Do you have problems chewing certain foods? Y N

Have your teeth changed over time (become shorter, thinner or worn)? Y N

Are your teeth becoming more crooked/crowded? Y N

Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? Y N

Airway

Have you been diagnosed with sleep apnea or participated in a sleep study? Y N

Do you have restless sleep, wake up feeling unrested, or feel tired during the day? Y N

Do you snore or have you been told you stop breathing in your sleep? Y N

Tooth Structure

Do you have a dry mouth? Y N

Are any teeth sensitive to hot, cold, biting or sweets? Y N

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? Y N

Do you frequently get food caught between any teeth? Y N

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? Y N

Gum and Bones

Have you ever been treated for periodontal (gum) disease or been told you have lost bone around your teeth? Y N

Have you ever experienced gum recession? Y N

Is there anyone with a history of periodontal disease in your family? Y N

Do your gums bleed when brushing, flossing or eating? Y N

Are your teeth becoming looser? Y N

Have you ever noticed an unpleasant taste or odor in your mouth? Y N

For Office Use Only *I verbally reviewed the medical/dental information above with the patient named herein.* Initials: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us for all of your dental needs. We are committed to providing you with the highest quality of care, and we offer a variety of convenient financial options to help you receive the dental care that you need and deserve. The following information is to inform you of our financial policy.

PAYMENT OPTIONS

We accept the following methods of payment: cash, check, and credit card (VISA, MasterCard, and Discover). Please note: There is a $50 fee for all returned checks. We extend pre-payment courtesies as well as offer payment plans. We have also partnered with third-party financing companies for extended payment options.

Your expected payment is due in full at the time of service unless prior arrangements have been made. We communicate all recommended treatment options and associated fees prior to the start of treatment.

INSURANCE

Dental insurance is incredibly complex, because each insurance policy has its own unique rules and stipulations that can vary greatly and can be hard to understand. If you have dental insurance, our knowledgeable team will help you understand your specific insurance plan in order to maximize your available benefits. We are also happy to file all paperwork and claims on your behalf.

Please keep in mind that your insurance policy is a specific contract between you and your insurance company. We are not a party to that contract and cannot guarantee coverage or benefits. We do our very best to collect all the information that we can from your insurance company prior to you receiving dental care so that we can provide you with the most accurate estimates of your coverage. We kindly request that you notify our office prior to your appointment with any changes in your dental insurance policy. If the information provided is incorrect, you will be responsible for payment.

APPOINTMENTS

Your scheduled appointment is a time that we have reserved exclusively for you. We have various methods of reminding you of upcoming appointments. We understand that there may be times when you are unable to keep your scheduled appointment, and we request that you notify our office with at least 48 hours notice.

MINORS

For parents or guardians of minors, the parent or guardian that accompanies the minor to their visit assumes financial responsibility for the minor's account.

I understand the above information and agree to its contents.

Signature: _____ DATE: _____

(Patient/responsible party)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please note: you may refuse to sign this acknowledgement.

I have received, read, and understand this office's Notice of Privacy Practices.

Signature_____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prevented obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other

If other, please specify:

_____

Date_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AN D HOW YOU CAN GET 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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **9/23/2013** and 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, 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, and we will provide copies of the new Notice 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.

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 related to HIV, genetic, alcohol &/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 information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involving 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.

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 may use or 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, 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 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. Dept. of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI 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 PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to subpoena or court order.

Health Oversight Activities. We may disclose your PHI 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 to monitor the health care system, government programs and compliance with civil rights.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process instituted by someone else 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 PHI 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.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. 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.

Other Uses & Disclosures of PHI.
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided in this Notice (or as otherwise permitted by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS
Access. You have the right to view or get copies of your PHI, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information 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 have the right to 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 for an 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 PHI, you must submit in writing to the Privacy Official. If you request this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.

Right to Request a Restriction. You have the right to request additional restriction on our use or disclosure of your PHI 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.

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 Website or by e- mail.

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, if you disagree with a decision we made about access to your PHI 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 locations, you may send a complaint to us using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file this complaint 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 for the U.S. Dept. of Health and Human Services.

Dr. Anjali Talwar, Dr. Michael Cheng, Dr. Kevin Wegrzyn
Family Roots Dentistry
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E-mail: Office@FamilyRootsDentistry.com

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Patient Photo Release Form

I _____, hereby authorize Drs. Talwar, Cheng, and Wegrzyn or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:
_____I do not mind if my photographs are used in any of the above stated situations.
_____I only agree to have my teeth shown without any identifying features.

Signed_____Date_____

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Primary Dental Insurance (if applicable)

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name _____ Relation: _____

Insured's DOB: _____ /_____/ _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name _____ Relation: _____

Insured's DOB: _____ /_____/ _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____