HAROLD PACKMAN, D.M.D, P.A.

PERIODONTAL HEALTHCARE SPECIALISTS

PATIENT INFORMATION (CONFIDENTIAL)

Date: _____

Name: _____
PLEASE CIRCLE: Mr. Mrs. Ms. Dr.

Address: _____

City/St/Zip: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **E-Mail:** _____

PLEASE CIRCLE: Minor Single Married Separated Divorced Widowed

Date of Birth: _____

Social Security #: _____

Driver License #: _____

Employer: _____
Occupation

_____
Address City/St/Zip

Spouse: (If Minor Parent or Guardian) _____ **Phone #:** _____

Date of Birth: _____ **Social Security #:** _____

Employer: _____
Occupation

General Dentist: _____
Phone #:

How did you hear about our office:

PLEASE CIRCLE: My Dentist Insurance Co. Internet Other

PRIMARY DENTAL INSURANCE

Insured: _____ | _____
Relationship to Patient

Date of Birth | Social Security # | ID #

Employer: _____ | _____
Group/Policy #:

Insurance Co: _____ | _____
Phone #

Mailing Address

SECONDARY DENTAL INSURANCE

Insured: _____ | _____
Relationship to Patient

Date of Birth | Social Security # | ID #

Employer: _____ | _____
Group/Policy #:

Insurance Co: _____ | _____
Phone #

Mailing Address

NOTE TO PATIENT: The following questions are for your benefit. They assure any treatment in the future will take into consideration your past and present health status.

MEDICAL HISTORY

Check any of the following that apply to you:

_____ Heart Murmur	_____ Diabetes	_____ High Blood Pressure	_____ Joint Replacement
_____ Heart Surgery	_____ Cancer	_____ Kidney Disease	_____ Arthritis
_____ Heart Failure	_____ Stomach Ulcer	_____ Thyroid Disease	_____ Cosmetic Surgery
_____ Stroke	_____ Acid Reflux	_____ Liver Disease	_____ Child Birth(s)
_____ Rheumatic Fever	_____ Sinus Trouble	_____ Blood Transfusion	_____ Drug Addiction
_____ Pacemaker	_____ Asthma	_____ HIV Infection	_____ Alcoholism
_____ Heart Valve Prosthesis	_____ Persistent Cough	_____ Hepatitis	_____ Psychiatric Care
_____ Epilepsy/Seizures	_____ Emphysema	_____ Venereal Disease (Syphilis, Gonorrhea, etc.)	_____ Other (Describe) _____
_____ Glaucoma	_____ Tuberculosis		

1. Is there a history of diabetes in your immediate family? No - Yes > whom: _____
2. Date of last complete physical examination: _____
3. Are you currently taking any Medications? No - Yes > please list: _____
4. Do you take Aspirin or Vitamins daily? No - Yes > please list: _____
5. Are you allergic or had adverse reactions to any medications, anesthetics, latex, etc.? No - Yes > please list: _____
6. Do you smoke or chew tobacco? No - Yes > please list: _____ How many or how often Per Day ? _____ How Many Years? _____

Over >

7. **Has there been any change in your general health within the last year?** No - Yes > please explain: _____

_____

8. **Have you been under a doctor's care, hospitalized or seriously ill in the past 2 years?** No - Yes > please explain: _____

_____

9. **Are you required to restrict your diet, work or activities in any way?** No - Yes > please explain: _____

_____

10. **Are you under a great deal of stress on a daily basis, or has your daily stress increased?** No - Yes > please explain: _____

_____

11. **Do you have frequent: Headaches:** No - Yes **Migraines:** No - Yes What area of the head? _____ Duration: _____

12. **Do you have any disease, condition or problem not listed above that you feel we should know about?** No - Yes > please explain:

_____

_____

Women Only:

1. Are you pregnant: Y~N If yes, due date: _____ 2. Is your menstrual cycle regular: Y~N
3. Have you reached menopause: Y~N 4. Are you experiencing any menopausal symptoms: Y~N

DENTAL HEALTH HISTORY

Check any of the following that apply to you:

_____ Injury to Face or Jaw
_____ Slow Healing Mouth Sores
_____ Fever Blisters
_____ Mouth Ulcers
_____ Swollen Gums
_____ Bleeding Gums
_____ Sensitivity to Hot
_____ Sensitivity to Cold
_____ Mouth Odor
_____ Bad taste in Mouth
_____ Loose Teeth
_____ Change in Bite
_____ Grind or Clench Teeth
_____ Tired or Sore Jaw Muscles
_____ Aches in Jaw Joint
_____ Clicking/Popping in Jaw
_____ Jaw Locking - Open or Closed
_____ Other (Describe)

_____

Which of the following do you use on a daily basis:

_____ **Bite Plane/Night Guard**
_____ **Toothbrush**
_____ **Floss**
_____ **Toothpicks**
_____ **Proxabrush**
_____ **End-Tuft Brush**
_____ **Other** (Describe) _____

Check any of the following treatment(s)/appliance that you currently have or have had in the past:

_____ **Periodontic** _____ **Orthodontic** _____ **Oral Surgery**

1. Are you currently experiencing any pain in your mouth? No - Yes >please explain nature of pain & location:

_____

2. Are you happy with the appearance of your teeth? No - Yes

3. Do you feel strongly about keeping your teeth for the rest of your life? No - Yes

4. Do you have difficulty chewing? No - Yes > please explain: _____

5. Is it difficult to open your mouth wide? No - Yes > please explain: _____

6. Are you worried about receiving dental treatment? No - Yes > please explain: _____

_____

Authorization and Release::

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to perform any and all forms of treatment, medication and therapy, that may be indicated. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my dependent to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that a finance charge will be rendered for any overdue balance.

X _____
Signature of patient (or parent/guardian if minor) Date

X _____
Signature of Attending Doctor Date

JAN '14

Harold Packman, DMD

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 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 12/06/02 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice any time, provided applicable law permits such changes. 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 of 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 or 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 for any purpose. If you give us authorization, you may revoke it in writing at any given 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 health care 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 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 a reasonable inference 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 safety or the health safety of others.

National Security: We may disclose to military authority 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 institutions or law enforcement officials 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 $.50 for each page, $25.00 per hour for staff time to locate and copy your health information and postage if you want the mailed to you. If you request an alternative format, 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, 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.

Restrictions: 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 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, provide a satisfactory explanation as to 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 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 any questions, 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 complain 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.

HAROLD PACKMAN, DMD

ACKNOWLEDGEMENT 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

For Official Use Only

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 us from obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____