Welcome to **Cetnar Dental**! We are so glad you are visiting us! We want to get to know you better, please complete the following forms. If you have any questions please don't hesitate to ask.

PATIENT **LAST** NAME: _____ **FIRST** NAME: _____

How do you wish to be addressed? _____ Birth Date _____

Address _____ City _____ State _____ Zip_____

Phone Number (Home) _____ (Cell) _____

Email _____

## DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit _____ Date of last dental x-rays _____

What did you like **most** about your previous dentist? _____

What did you like **least** about your previous dentist? _____

| **Please check if you have/had:** | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bad breath | ☐ | ☐ | Head, neck or jaw pain or aches | ☐ | ☐ |
| Blisters on the lips or mouth | ☐ | ☐ | Lip or cheek biting | ☐ | ☐ |
| Burning sensation on tongue | ☐ | ☐ | Loose teeth or broken fillings | ☐ | ☐ |
| Difficulty chewing | ☐ | ☐ | Mouth breathing | ☐ | ☐ |
| Cigarette, pipe, or cigar smoking | ☐ | ☐ | Orthodontic treatment (braces) | ☐ | ☐ |
| Smokeless tobacco (chew/snuff) | ☐ | ☐ | Nitrous Oxide (laughing gas) | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | Periodontal treatment (gum disease) | ☐ | ☐ |
| Food collection between teeth | ☐ | ☐ | Teeth sensitivity (cold, hot, sweet, pressure) | ☐ | ☐ |
| Clench or grind teeth | ☐ | ☐ | How often do you floss? _____ | | |
| Growths or sore spots in your mouth | ☐ | ☐ | How often do you brush? _____ | | |
| Gums swollen, tender or bleed? | ☐ | ☐ | Have you ever had an allergic reaction to Novocaine, local, or general anesthetic? | ☐ | ☐ |

**On a scale of 1 - 10, please rate what <u>you</u> think of:**

**Your smile:** 1 2 3 4 5 6 7 8 9 10

**The <u>shade</u> of your teeth:** 1 2 3 4 5 6 7 8 9 10

Have you ever had difficulty with dental treatment in the past? _____

If there was one thing you could change about your smile, what would it be?_____

Are there any questions/concerns that have not been addressed in the above questions?

_____

**How did you hear about us?**

- Who selected this office: ☐ You ☐ Spouse ☐ Parent ☐Employer
- Where did you find the phone number to this office?_____
- If you were referred, whom may we thank for referring you? _____

We offer a variety of services to enhance your comfort, and keep your smile beautiful. Please **circle** any services below you would like our friendly staff to discuss with you during your visit:

| | | | | |
|---|---|---|---|---|
| Teeth whitening | Braces/Orthodontics | Invisalign | Veneers | Sealants |
| Implants | Crowns | Extended Payment Plans | Partials or Dentures | Nighttime / Sports / Sleep Apnea appliances |

**PATIENT MEDICAL HISTORY**

Although dental personnel primarily treat your mouth, research has shown that there is an oral-systemic connection to your health. Health conditions that you may have, or medication that you may be taking, could have an important interrelationship with the care you will receive. Thank you for answering the following questions:

Physician's Name _____ Date of Last visit _____

Physicians Address _____

Have you had any hospitalization or emergency room visits in the last 5 years? If yes please explain Yes No

_____

Are you taking any medications? If yes please list them below. Yes No

_____

(Women) Please Circle:

- Are you pregnant or possibly pregnant? Yes No Nursing? Yes No
- Taking birth control pills? Yes No

**Please check if you have/had:**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Allergies, hay fever, sinusitis | ☐ | ☐ | Anemia | ☐ | ☐ | Arthritis, Rheumatism | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ | Artificial joints | ☐ | ☐ | Asthma | ☐ | ☐ |
| Bleeding abnormally with operations or surgery | ☐ | ☐ | Blood disease, clotting disorders | ☐ | ☐ | Cancer/Chemotherapy/Rad | ☐ | ☐ |
| Chemical dependency | ☐ | ☐ | Circulatory problems | ☐ | ☐ | Cortisone treatments | ☐ | ☐ |
| Cough, persistent or bloody | ☐ | ☐ | Diabetes | ☐ | ☐ | Emphysema | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Fainting | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Headaches | ☐ | ☐ | Heart problems or murmurs | ☐ | ☐ | Hepatitis type ____ | ☐ | ☐ |
| Herpes | ☐ | ☐ | High blood pressure | ☐ | ☐ | Any immune deficiency | ☐ | ☐ |
| Jaundice | ☐ | ☐ | Kidney disease | ☐ | ☐ | Low blood pressure | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Osteopenia | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Respiratory disease | ☐ | ☐ | Rheumatic disease | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | Scarlet fever | ☐ | ☐ | Shortness of breath | ☐ | ☐ |
| SInus trouble | ☐ | ☐ | Sickle cell anemia | ☐ | ☐ | Skin rash | ☐ | ☐ |
| Slow healing or easily bruising | ☐ | ☐ | Stroke | ☐ | ☐ | Swelling of feet or ankles | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | Tonsillitis | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ |
| Tumor or growth on head/neck | ☐ | ☐ | Ulcer | ☐ | ☐ | Venereal disease | ☐ | ☐ |
| Unexplained weight loss | ☐ | ☐ | Do you wear contact lenses | ☐ | ☐ | Do you consume alcoholic beverages? | ☐ | ☐ |
| Latex Allergy? | ☐ | ☐ | Allergic to penicillin, aspirin, or other drugs? | ☐ | ☐ | | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

Signature of Patient, Parent, Guardian_____ Date _____

Doctor/Team member who reviewed information with patient _____ Date _____

## EMERGENCY CONTACT INFORMATION

In the unlikely event of an emergency please contact:

Name_____ Relationship _____ Phone # _____

Name_____ Relationship _____ Phone # _____

## PATIENT INSURANCE INFORMATION

| Primary Insurance | Secondary Insurance |
|---|---|
| Subscriber Name _____ | Subscriber Name _____ |
| Subscriber ID _____ | Subscriber ID _____ |
| Date of Birth _____ SS # _____ | Date of Birth _____ SS # _____ |
| Relationship to subscriber Self Spouse Child Other | Relationship to subscriber Self Spouse Child Other |
| Employer Name _____ | Employer Name _____ |
| Employer Phone _____ | Employer Phone _____ |
| Insurance Company _____ | Insurance Company _____ |
| Insurance Group _____ | Insurance Group _____ |
| Insurance Phone _____ | Insurance Phone _____ |

### Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance. I attest to the accuracy of the information on this page. I acknowledge that I have been offered a notice of the office's privacy practice information.

### Electronic Communications

I consent to receive HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, and health care operations, I understand that there is no obligation to receive these electronic communications. Message/ data rates may apply, and I may opt out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text.

### Cancellation Policy

This appointment time has been reserved just for you. We appreciate a **24-hour notice** if you are unable to keep your appointment. A fee of $45 will be charged for missed appointments.
I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible party, if under 18)

# NOTICE OF PRIVACY PRACTICES
# Robin P. Cetnar
# 101 West Water St.
# Saxonburg, PA 16056

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Your Rights**
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Our Uses and Disclosures**
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, government requests
- Respond to lawsuits and legal actions

## Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yet" to all reasonable requests

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information listed above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

(If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.)
In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures: How do we typically use or share your health information?

We typically use or share your health information in the following ways.
**Treat you:** We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition
**Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
**Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
**Help with public health and safety issues**
We can share health information about you for certain situation such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research:** We can use or share your information for health research.
**Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
**Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.
**Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
**Address workers' compensation, law enforcement, and other government requests.**
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.
**Special Considerations for SUD Record Management:** If we receive SUD (substance use disorder) records as the result of a disclosure authorized by you, we are permitted to use and disclose those records for treatment, payment, and/or operations (TPO) purposes in accordance with HIPAA regulations unless you revoke the authorization in writing. We may disclose those records to public health authorities without your consent, but only if those records have been fully de-identified according to HIPAA regulations. We will not release those records or your testimony regarding those records for matters of criminal, administrative, legislative, or civil proceedings against you by a local, state, or federal authority unless we receive a court order or a separate and specific patient consent from you. You may request an accounting of all TPO disclosures of SUD records made electronically for up to three years prior to the date of the request. We will not use or disclose your SUD records to fundraise for our own benefit.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.**

Date of Posting: _____
Privacy Officer: _____ Phone: _____
NOPP form modified from HHS.gov website