PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (_____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (_____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent Social Security # _____

Name of Primary Dental Insurance Company _____ Group # _____

Name of Secondary Dental Insurance Company _____ Group # _____

In case of emergency, who should be notified? _____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Arthritis	☐ Headaches	☐ Psychiatric Care
☐ Artificial Heart Valves or Joints, Screws, etc	☐ Heart Murmur	☐ Radiation Treatment
☐ Back Problems	☐ Heart Problems	☐ Recent Weight Loss
☐ Bleeding Abnormally	☐ Hemophilia	☐ Respiratory Disease
☐ Blood Disease	☐ Hepatitis, Jaundice, or Liver Disease	☐ Rheumatic Fever
☐ Cancer	☐ Hernia Repair	☐ Sinus Problems
☐ Chemical Dependency	☐ High Blood Pressure	☐ Special Diet
☐ Chronic Diarrhea	☐ HIV/AIDS	☐ Stroke
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Diabetes	☐ Nervous Problems	☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

(Women) Are you or do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

(Continued on next page)

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ _______________________
Signature of Patient, Parent, Guardian, or Personal Representative — Date

____ _______________________
Please print name of Patient, Parent, Guardian, or Personal Representative — Date

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____

Is the patient taking any new medications? _____________ If so, what? ______________________________

_____________________ Date

_____________________________________ Patient Signature

_____________________ Date

_____________________________________ Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____

Is the patient taking any new medications? _____________ If so, what? ______________________________

_____________________ Date

_____________________________________ Patient Signature

_____________________ Date

_____________________________________ Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____

Is the patient taking any new medications? _____________ If so, what? ______________________________

_____________________ Date

_____________________________________ Patient Signature

_____________________ Date

_____________________________________ Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____

Is the patient taking any new medications? _____________ If so, what? ______________________________

_____________________ Date

_____________________________________ Patient Signature

_____________________ Date

_____________________________________ Dentist Signature

MILLCREEK DENTAL ARTS

Keith C. Schloss, DMD

NOTICE OF PRIVACY PRACTICES. 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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references co individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain – and we have the obligation to provide – a paper copy of this notice from us at your first delivery of services date.
- The right to provide – and we are obligated to receive – a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature: _____ Date: _____

Please contact us for more information:
Millcreek Dental Arts
4020 Sterrettania Road
Erie, PA 16506
(814)835-3740
www.MillcreekDentalArts.com

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775